Rheumatology Patient Enrollment and Prescription Form

Gentry HEALTH SERVICES
Together Creating a Path to Better Care

Tel: 844-443-6879 **Fax: 844-329-2447**

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, Ohio.

PATIENT INFORMATION

Patient Name _____
DOB ___/___/_____ SSN _____ Gender_____
Weight _____ Height _____ Phone _____
Address _____
City, State, Zip _____
Cell Phone _____ E-Mail _____
PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name _____
Insurance Co. Phone _____ Group# _____
Policy Holder Name _____
Policy Holder Employer _____
Relationship to Patient _____
ID# _____ RxBIN _____ PCN_____

PRESCRIBER INFORMATION

Prescriber's Name _____
Practice Name _____
DEA _____ NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Office Contact Person _____
Office Contact EMAIL _____
Prescription Date _____ Date Needed _____

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber Signature _____

Ship to: ☐ Patient ☐ Prescriber's Office ☐ Discount Drug Mart

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis: _____ Date of Diagnosis _____ ICD-10 Code: _____
Has a TB test been performed? ☐ YES ☐ NO If yes, is the patient currently being treated? ☐ YES ☐ NO
Has patient been evaluated for HBV? ☐ YES ☐ NO If positive, is the patient currently being treated? ☐ YES ☐ NO
Does the patient have any other health conditions? ☐ YES ☐ NO If yes: _____
Drug Allergies _____ Latex Allergy? ☐ YES ☐ NO
Prior DMARD usage and for how long? _____

PRESCRIPTION INFORMATION *(DAW requests must be handwritten)*

☐ **Actemra® (tocilizumab)**				
☐ Prefilled Syringe ☐ ACTPen		☐ Inject 162mg SQ every _____ week(s)	Qty: _____	
☐ I.V. Vials (provide weight)		☐ Infuse _____ mg/kg every _____ week(s)	Qty: _____	Refills _____
☐ **Cosentyx® (secukinumab)**	☐ Prefilled Syringe ☐ Sensoready® Pen	***See Psoriatic Arthritis Form for PSA Prescribing**		
☐ **Ankylosing Spondylitis**	STARTER Dose: 150MG SQ at weeks 0, 1, 2, 3, & 4		Qty: 10	
☐ **Ankylosing Spondylitis**	MAINTENANCE Dose: Inject 150MG once every 4 weeks		Qty: 2	Refills _____
☐ **Cimzia® (certolizumab)**	***INITIAL DOSE***	☐ *Inject 400mg SQ at Days 1, 14, & 28*	Qty: 6	
☐ 200mg/1ml Powder Kit		☐ Inject 400mg SQ every 4 weeks	Qty: 2	
☐ 200mg/1ml Prefilled Syringe Kit		☐ Inject 200mg SQ every 2 weeks	Qty: 2	Refills _____
☐ **Enbrel® (entanercept)**		☐ Inject 50mg SQ weekly	Qty: 4	
☐ Vial ☐ Prefilled Syringe		☐ Inject 50mg SQ twice weekly	Qty: 8	
☐ SureClick® Autoinjector		☐ Inject 25mg SQ twice weekly	Qty: 8	
☐ Mini Prefilled Cartridge (for use with AutoTouch reusable autoinjector only)				Refills _____
☐ **Humira® (adalimumab)**				
☐ 40mg Prefilled Pen		☐ Inject 40mg SQ every other week	Qty: 2	
☐ 40mg Prefilled Pen		☐ Inject 40mg SQ every week	Qty: 4	
☐ 80mg Prefilled Pen		☐ Inject 80mg SQ every other week	Qty: 2	
☐ **Kevzara® (sarilumab)**	**Prefilled Syringe**	☐ Inject 150mg SQ every other week	Qty: 2	
		☐ Inject 200mg SQ every other week	Qty: 2	Refills _____
☐ **Orencia® (abatacept)**	***INITIAL DOSE***	☐ *Infuse _____mg, then Inject 125mg SQ within 24 hours*	*Qty: _____*	
☐ ClickJect Autoinjector		☐ Inject 125mg SQ weekly	Qty: 4	
☐ Prefilled Syringe				Refills _____
☐ **Otezla® (apremilast)**	***TITRATION PACK***	☐ *Take 1 tablet as directed per titration schedule on packaging*	*Qty: 55*	
	Maintenance Dose	☐ Take 1 tablet (30mg) twice daily as directed	Qty: 60	Refills _____
☐ **Rinvoq® (upadacitinib)**	15mg ER Tablet	☐ Take 1 tablet once daily	Qty: 30	Refills _____
☐ **Simponi® (golimumab)**				
☐ Prefilled Syringe ☐ SmartJect®		☐ Inject 50mg SQ once a month	Qty: 1	Refills _____
☐ **Stelara® (ustekinumab)**	***INITIAL DOSE***	☐ *Inject 45mg SQ on Days 0 & 28*	*Qty: 2*	
☐ Vial ☐ Prefilled Syringe	***INITIAL DOSE***	☐ *Inject 90mg SQ on Days 0 & 28*	*Qty: 2*	
		☐ Inject 45mg SQ every 12 weeks	Qty: 1	
		☐ Inject 90mg SQ every 12 weeks	Qty: 1	
☐ **Xeljanz® (tofacitinib)**	5mg Tablet	☐ Take 1 tablet twice daily	Qty: 60	
	11mg XR Tablet	☐ Take 1 tablet once daily	Qty: 30	Refills _____