

Atopic Dermatitis

Patient Enrollment and Prescription Form

P: 1-844-443-6879 F: 1-844-329-2447

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 _____ ICD-10 Code _____

Date of Diagnosis _____ Body Surface Affected: _____ %

Patient has moderate to severe atopic dermatitis (AD) that is inadequately controlled on prior or current topical therapy

Drug Allergies _____ Latex Allergy? YES NO

Failed Prior therapies?

Topical Corticosteroids:

_____ to _____
 _____ to _____

Topical therapy not appropriate

Reason: _____

Systemic Corticosteroids, Immunosuppressants and/or Phototherapy:

_____ to _____
 _____ to _____
 _____ to _____

Systemic corticosteroids not appropriate

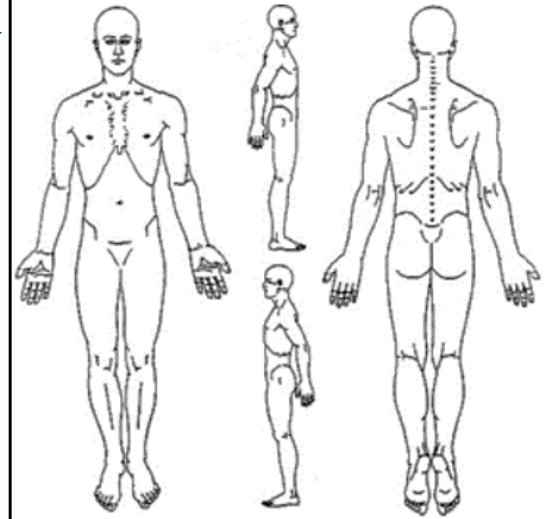
Immunosuppressants not appropriate

Phototherapy not appropriate

Reason: _____

Does the patient have history of conjunctivitis or keratitis? YES NO

Additional Comments _____



Affected Areas: Hands Feet
 Scalp Groin Nails Face
 Other: _____

PRESCRIPTION INFORMATION

(please indicate days supply if different than suggested days supply)

Patient is 18 years of age or older

Dupixent® (dupilumab) 300 mg/2 mL Pre-filled Syringe 300 mg/2 mL Pre-filled Pen

STARTER DOSE: 600MG SQ at week 0, 300MG SQ at weeks 2 & 4 Quantity: 4 Syringes Refills _____

MAINTENANCE DOSE: 300MG SQ once every 2 weeks Quantity: 2 Syringes Refills _____

ADDITIONAL SUPPORTIVE MEDICATION

Medication Name and Dosage Form	Strength	Directions	Qty	Refills