



Asthma

Patient Enrollment & 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: _____ Years since diagnosed: _____
 Number of severe exacerbations in the past 12 months: _____
 Patient has moderate-to-severe asthma that requires add-on maintenance treatment Atopic comorbidities
 Eosinophil levels (if available) _____ cells/mcL Test date _____
 IgE level (if available) _____ Test date _____
 Drug Allergies: _____ Latex Allergy? YES NO
 Other Disease States or Comorbidities _____

*****Please attach the patient's most recent CBC with differential**

Current Asthma Regimen

Therapy Type	Drug Name	Duration
<input type="checkbox"/> Bronchodilator Therapy	_____	_____ to _____
<input type="checkbox"/> Inhaled Corticosteroid	_____	_____ to _____
<input type="checkbox"/> Combination Therapy	_____	_____ to _____
<input type="checkbox"/> Oral Corticosteroid	_____	_____ to _____
<input type="checkbox"/> Other	_____	_____ to _____
<input type="checkbox"/> Other	_____	_____ to _____

PRESCRIPTION INFORMATION

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 _____

Dupixent® (dupilumab) 200 mg/1.14 mL Pre-filled Syringe 200 mg/1.14 mL Pre-filled Pen
 STARTER DOSE: 400MG SQ at week 0, 200MG SQ at weeks 2 & 4 Quantity: 4 Syringes Refills _____
 MAINTENANCE DOSE: 200MG SQ once every 2 weeks Quantity: 2 Syringes Refills _____

Dupixent® (dupilumab) 100 mg/0.67 mL Pre-filled Syringe
 MAINTENANCE DOSE: 100MG SQ every other week as directed Quantity: 2 Syringes Refills _____

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.