Psoriasis and Psoriatic Arthritis
Patient Enrollment and Prescription Form

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.

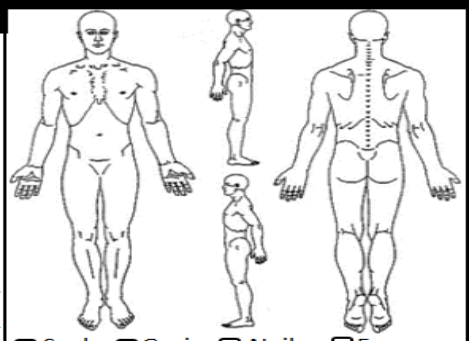
Prescriber Signature _____

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 _____ ICD-10 Code _____
Date of Diagnosis _____ Body Surface Affected: _____ %
TB positive? ☐YES ☐NO If yes, is the patient currently being treated? ☐YES ☐NO
HBV positive? ☐YES ☐NO If yes, is the patient currently being treated? ☐YES ☐NO
Drug Allergies _____ Latex Allergy? ☐YES ☐NO
Failed Prior therapies? ☐DMARDS: _____ Duration: _____
☐Topical: _____ Duration: _____
☐Phototherapy: _____ Duration: _____
☐Specialty Meds: _____ Duration: _____
Does the patient have CHF? ☐YES ☐NO Does the patient have MS? ☐YES ☐NO
Additional Comments _____



☐Scalp ☐Groin ☐Nails ☐Face
☐Other: _____

PRESCRIPTION INFORMATION

☐ **Cimzia® (certolizumab)** ☐200mg/1ml Kit ☐200mg/1ml Prefilled Syringe
☐ Plaque Psoriasis: 400mg SQ every other week Quantity _____ Refills _____
☐ Psoriatic Arthritis: 400mg SQ Day 0, 14, and 28, then 200mg every other week Quantity _____ Refills _____

☐ **Cosentyx® (secukinumab)** ☐Prefilled Syringe ☐Sensoready® Pen
☐ Plaque Psoriasis: 300MG SQ at weeks 0, 1, 2, 3, & 4 then q4weeks Quantity _____ Refills _____
☐ Psoriatic Arthritis: 150MG SQ at weeks 0, 1, 2, 3, & 4 then q4weeks Quantity _____ Refills _____

☐ **Enbrel® (entanercept)** ☐25mg Vial ☐Prefilled Syringe ☐50mg SureClick ☐50mg Mini Prefilled Cartridge
☐ Directions: Inject 50mg SQ once weekly Quantity _____ Refills _____
☐ Directions: Inject 50mg SQ twice weekly Quantity _____ Refills _____
☐ Directions: Inject 25mg SQ twice weekly Quantity _____ Refills _____

☐ **Humira® (adalimumab)** ☐Prefilled Syringe ☐Prefilled Pen ☐**Please check if Starter Dose is NOT needed**
☐ Psoriasis: 80mg SQ Day 1, 40mg SQ Day 8 and 22 then 40mg SQ every other week Quantity _____ Refills _____
☐ HS 40mg Dose: 160mg SQ Day 1, then 80mg on Day 15 then 40mg SQ once weekly Quantity _____ Refills _____
☐ HS 80mg Dose: 160mg SQ Day 1, 80mg Day 15 then 80mg SQ every other week Quantity _____ Refills _____

☐ **Otezla® (apremilast) 30mg Tablet** ☐**Please check if Starter Dose is NOT needed**
☐ Directions: Take starter dose as directed then take one tab twice daily Quantity _____ Refills _____

☐ **Rinvoq® (upadacitinib) 15mg Tablet**
☐ Directions: Take 1 tablet daily as directed Quantity _____ Refills _____

☐ **Siliq™ (brodalumab)** ☐210mg Prefilled Syringe ☐**Please check if Starter Dose is NOT needed**
☐ Directions: Inject 210mg SQ on week 0, 1 and 2 then every 2 weeks thereafter Quantity _____ Refills _____

☐ **Simponi® (golimumab)** ☐50mg/0.5ml Prefilled Syringe ☐50mg/0.5ml Smartject Autoinjector
Directions: Inject 50mg SQ once monthly Quantity _____ Refills _____

☐ **Skyrizi™ (risankizumab-rzaa)** ☐150mg Syringe ☐150mg Pen ☐**Please check if Starter Dose is NOT needed**
☐ Directions: Inject 150mg SQ on Day 0 and Day 28 then every 12 weeks Quantity _____ Refills _____

☐ **Stelara® (ustekinumab) Prefilled Syringe** ☐45mg ☐90mg ☐**Please check if Starter Dose is NOT needed**
☐ Directions: Inject 1 syringe SQ on Day 0 and Day 28 then every 12 weeks Quantity _____ Refills _____

☐ **Taltz® (ixekizumab)** ☐Prefilled Syringe ☐Autoinjector ☐**Please check if Starter Dose is NOT needed**
☐Psoriatic Arthritis: 160mg week 0, then 80mg q4weeks Quantity _____ Refills _____
☐Plaque Psoriasis: 160mg week 0, 80mg weeks 2, 4,6, 8, 10 & 12, then 80mg q4weeks Quantity _____ Refills _____

☐ **Tremfya™ (guselkumab)** ☐100mg Syringe ☐100 mg One-Press ☐**Please check if Starter Dose is NOT needed**
Directions: Inject 100mg SQ at weeks 0, 4, and every 8 weeks thereafter Quantity _____ Refills _____