



Rheumatology 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: _____ 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)

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