



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

Crohn's Disease / Ulcerative Colitis Patient Enrollment & Prescription Form

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

PATIENT INFORMATION PRESCRIBER 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

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

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

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: _____ New to therapy? YES NO
 TB negative? YES NO Hepatitis B negative? YES NO
 Drug Allergies _____ Latex Allergy? YES NO
 Prior Therapy and for how long? _____
 Reason for Discontinuation? _____
 Any other relevant medical info? _____

PRESCRIPTION INFORMATION (DAW requests must be handwritten)

Cimzia® (certolizumab) 200mg/1ml Prefilled Syringe Starter Kit
 Directions: Inject 400 mg SQ initially and at Weeks 2 and 4 Qty: 6 Refills 0
 200mg/1ml Prefilled Syringe for Maintenance Dosing
 Directions: Inject 400 mg SQ every 4 wks OR Inject 400 mg SQ every 2 wks Qty: QS 30 Days Refills _____

Humira® (adalimumab) Crohn's 40mg Starter Package
 Directions: Inject 160 mg SQ initially followed by 80mg two weeks later (Day 15) Qty: 1 KIT Refills 0
 40mg Prefilled Pen Carton for Maintenance Dosing
 Directions: Inject 40mg every other week Qty: QS 30 Days Refills _____

infliximab 100mg/20ml Vial Qty: QS 30 Days Refills _____
 Directions: Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks OR Infuse 10mg/kg at 0, 2 and 6 weeks, then every 8 weeks

Rinvoq® (upadacitinib) INDUCTION DOSE Take one 45mg tab once daily for 8 weeks Qty: 28 Refills one
 MAINTENANCE DOSE Take one 15mg tablet once daily Qty: 30 Refills _____
 Take one 30mg tablet once daily Qty: 30 Refills _____

Simponi® (golimumab) TYPE: Smartject® Autoinjector Prefilled Syringe STRENGTH: 100mg
 Directions: Inj 200 mg SQ initially at Week 0, followed by 100 mg at Week 2, then 100 mg every 4 weeks Qty: QS 30 Days Refills _____

Stelara® (ustekinumab) 130mg Single Dose Vial 90mg single-dose prefilled syringe
 260mg Starter (up to 55kg): Infuse intravenously over a period of at least one hour as directed
 390mg Starter (greater than 55kg to 85kg): Infuse intravenously over a period of at least one hour as directed
 520mg Starter (greater than 85mg): Infuse intravenously over a period of at least one hour as directed
 MAINTENANCE: Inject 90mg SQ every 8 weeks after initial intravenous dose 60 Days Supply? YES NO Refills _____

Xeljanz® (tofacitinib) INDUCTION DOSE Take one 10mg tab twice daily for 8 weeks Qty: 120
 Take one 22mg XR tab once daily for 8 weeks Qty: 30
 MAINTENANCE DOSE Take one 5mg tablet twice daily Qty: 60 Refills _____
 Take one 10mg tablet twice daily Qty: 60 Refills _____
 Take one 11mg XR tablet once daily Qty: 30 Refills _____
 Take one 22mg XR 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.