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_____

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

Drug Allergies: _____ Latex Allergy? ☐YES ☐NO
Other Disease States or Comorbidities _____

Current Asthma Regimen

Therapy Type	Drug Name	Duration
☐Bronchodilator Therapy		_____ to _____
☐Inhaled Corticosteroid		_____ to _____
☐Combination Therapy		_____ to _____
☐Oral Corticosteroid		_____ to _____
☐Other		_____ to _____
☐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 _____

☐**XOLAIR® (omalizumab)** ☐ 75mg Pre-filled Syringe ☐ 150 mg Pre-filled Syringe
☐ 2 week dosing: Inject MG SQ every two weeks Quantity: _____ Refills _____
☐ 4 week dosing: Inject MG SQ every four weeks Quantity: _____ Refills _____