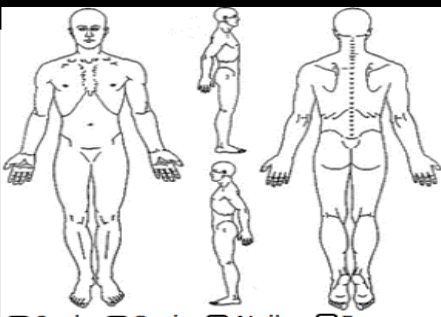


Psoriasis and Psoriatic Arthritis Patient Enrollment and Prescription Form

Tel: 844-443-6879 Fax: 844-329-2447 ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, Ohio.

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name _____	Prescriber's Name _____
DOB ____/____/____ SSN _____ Gender _____	Practice Name _____
Weight _____ Height _____ Phone _____	DEA _____ NPI _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Cell Phone _____ E-Mail _____	Phone _____ Fax _____
PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM	
Insurance Co. Name _____	Office Contact Person _____
Insurance Co. Phone _____ Group# _____	Office Contact EMAIL _____
Policy Holder Name _____	Prescription Date _____ Date Needed _____
Policy Holder Employer _____	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 _____
Relationship to Patient _____	
ID# _____ RxBIN _____ PCN _____	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> 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 _____	 <p><input type="checkbox"/> Scalp <input type="checkbox"/> Groin <input type="checkbox"/> Nails <input type="checkbox"/> Face <input type="checkbox"/> Other: _____</p>
Date of Diagnosis _____ Body Surface Affected: _____ %	
TB positive? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, is the patient currently being treated? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HBV positive? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, is the patient currently being treated? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Drug Allergies _____ Latex Allergy? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Failed Prior therapies? <input type="checkbox"/> DMARDS: _____ Duration: _____	
<input type="checkbox"/> Topical: _____ Duration: _____	
<input type="checkbox"/> Phototherapy: _____ Duration: _____	
<input type="checkbox"/> Specialty Meds: _____ Duration: _____	
Does the patient have CHF? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the patient have MS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Additional Comments _____	

PRESCRIPTION INFORMATION	
<input type="checkbox"/> Cimzia® (certolizumab) <input type="checkbox"/> 200mg/1ml Kit <input type="checkbox"/> 200mg/1ml Prefilled Syringe	
<input type="checkbox"/> Plaque Psoriasis: 400mg SQ every other week	Quantity _____ Refills _____
<input type="checkbox"/> Psoriatic Arthritis: 400mg SQ Day 0, 14, and 28, then 200mg every other week	Quantity _____ Refills _____
<input type="checkbox"/> Cosentyx® (secukinumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Sensoready® Pen	
<input type="checkbox"/> Plaque Psoriasis: 300MG SQ at weeks 0, 1, 2, 3, & 4 then q4weeks	Quantity _____ Refills _____
<input type="checkbox"/> Psoriatic Arthritis: 150MG SQ at weeks 0, 1, 2, 3, & 4 then q4weeks	Quantity _____ Refills _____
<input type="checkbox"/> Enbrel® (etanercept) <input type="checkbox"/> 25mg Vial <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 50mg SureClick <input type="checkbox"/> 50mg Mini Prefilled Cartridge	
<input type="checkbox"/> Directions: Inject 50mg SQ once weekly	Quantity _____ Refills _____
<input type="checkbox"/> Directions: Inject 50mg SQ twice weekly	Quantity _____ Refills _____
<input type="checkbox"/> Directions: Inject 25mg SQ twice weekly	Quantity _____ Refills _____
<input type="checkbox"/> Humira® (adalimumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Prefilled Pen <input type="checkbox"/> Please check if Starter Dose is NOT needed	
<input type="checkbox"/> Psoriasis: 80mg SQ Day 1, 40mg SQ Day 8 and 22 then 40mg SQ every other week	Quantity _____ Refills _____
<input type="checkbox"/> HS 40mg Dose: 160mg SQ Day 1, then 80mg on Day 15 then 40mg SQ once weekly	Quantity _____ Refills _____
<input type="checkbox"/> HS 80mg Dose: 160mg SQ Day 1, 80mg Day 15 then 80mg SQ every other week	Quantity _____ Refills _____
<input type="checkbox"/> Otezla® (apremilast) 30mg Tablet <input type="checkbox"/> Please check if Starter Dose is NOT needed	
Directions: Take starter dose as directed then take one tab twice daily	Quantity _____ Refills _____
<input type="checkbox"/> Rinvoq® (upadacitinib) 15mg Tablet	
Directions: Take 1 tablet daily as directed	Quantity _____ Refills _____
<input type="checkbox"/> Siliq™ (brodalumab) <input type="checkbox"/> 210mg Prefilled Syringe <input type="checkbox"/> 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 _____
<input type="checkbox"/> Simponi® (golimumab) <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe <input type="checkbox"/> 50mg/0.5ml Smartject Autoinjector	
Directions: Inject 50mg SQ once monthly	Quantity _____ Refills _____
<input type="checkbox"/> Skyrizi™ (risankizumab-rzaa) <input type="checkbox"/> 150mg Syringe <input type="checkbox"/> 150mg Pen <input type="checkbox"/> Please check if Starter Dose is NOT needed	
Directions: Inject 150mg SQ on Day 0 and Day 28 then every 12 weeks	Quantity _____ Refills _____
<input type="checkbox"/> SOTYKTU™ (deucravacitinib) 6mg Tablet	
Directions: Take 1 tablet daily with or without food	Quantity _____ Refills _____
<input type="checkbox"/> Stelara® (ustekinumab) Prefilled Syringe <input type="checkbox"/> 45mg <input type="checkbox"/> 90mg <input type="checkbox"/> 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 _____
<input type="checkbox"/> Taltz® (ixekizumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector <input type="checkbox"/> Please check if Starter Dose is NOT needed	
<input type="checkbox"/> Psoriatic Arthritis: 160mg week 0, then 80mg q4weeks	Quantity _____ Refills _____
<input type="checkbox"/> Plaque Psoriasis: 160mg week 0, 80mg weeks 2, 4, 6, 8, 10 & 12, then 80mg q4weeks	Quantity _____ Refills _____
<input type="checkbox"/> Tremfya™ (guselkumab) <input type="checkbox"/> 100mg Syringe <input type="checkbox"/> 100 mg One-Press <input type="checkbox"/> Please check if Starter Dose is NOT needed	
Directions: Inject 100mg SQ at weeks 0, 4, and every 8 weeks thereafter	Quantity _____ Refills _____
<input type="checkbox"/> VTAMA® (tapinarof) cream 60 gram tube	
Directions: Apply a thin layer of VTAMA cream to affected areas once daily	Quantity _____ Tube(s) _____ Refills _____
<input type="checkbox"/> ZORYVE™ (roflumilast) cream 60 gram tube	
Directions: Apply once daily to affected areas.	Quantity _____ Tube(s) _____ Refills _____