Crohn's Disease / Ulcerative Colitis
Patient Enrollment & 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: ____ 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 ____

☐ **Skyrizi® (risankizumab-rzaa)** ☐ 600 mg single-dose vial - induction ☐ 180mg single dose cartridge ☐ 360mg single dose cartridge
☐ INITIATION: Infuse 600 mg as initial IV dose at Week 0, Week 4, and Week 8 ☐ Qty: 60 Days
☐ MAINTENANCE: 180 mg by SQ injection at week 12, and every 8 weeks thereafter ☐ Qty: 60 Days Refills ____
☐ MAINTENANCE: 360 mg by SQ injection at week 12, and every 8 weeks thereafter ☐ Qty: 60 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 ____

☐ **Zeposia® (ozanimod)** ☐ 7 Day Starter ☐ 0.92mg Capsule
☐ INDUCTION DOSE: Take 0.23 mg once daily for days 1-4, then take 0.46 mg once daily for days 5-7 Qty: 1 Pack
☐ MAINTENANCE DOSE: Take 0.92 mg 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.