Rheumatology Patient Enrollment and Prescription Form

Gentry HEALTH SERVICES
Together Creating a Path to Better Care

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)*

☐ **Actemra® (tocilizumab)**
☐ Prefilled Syringe ☐ ACTPen ☐ Inject 162mg SQ every _____ week(s) Qty: _____
☐ I.V. Vials (provide weight) ☐ Infuse _____ mg/kg every _____ week(s) Qty: _____ Refills _____

☐ **Cosentyx® (secukinumab)** ☐ Prefilled Syringe ☐ Sensoready® Pen ☐ UnoReady® Pen
☐ **Ankylosing Spondylitis** STARTER Dose: 150MG SQ at weeks 0, 1, 2, 3, & 4 Qty: 10
☐ **Ankylosing Spondylitis** MAINTENANCE Dose: Inject 150MG once every 4 weeks Qty: 2 Refills _____

☐ **Cimzia® (certolizumab)** ***INITIAL DOSE*** ☐ *Inject 400mg SQ at Days 1, 14, & 28* Qty: 6
☐ 200mg/1ml Powder Kit ☐ Inject 400mg SQ every 4 weeks Qty: 2
☐ 200mg/1ml Prefilled Syringe Kit ☐ Inject 200mg SQ every 2 weeks Qty: 2 Refills _____

☐ **Enbrel® (entanercept)** ☐ Inject 50mg SQ weekly Qty: 4
☐ Vial ☐ Prefilled Syringe ☐ Inject 50mg SQ twice weekly Qty: 8
☐ SureClick® Autoinjector ☐ Inject 25mg SQ twice weekly Qty: 8
☐ Mini Prefilled Cartridge (for use with AutoTouch reusable autoinjector only) Refills _____

☐ **adalimumab - Preferred Brand Name** (if required must write DAW): _____
☐ 40mg Prefilled Pen ☐ Inject 40mg SQ every other week Qty: 2
☐ 40mg Prefilled Pen ☐ Inject 40mg SQ every week Qty: 4
☐ 80mg Prefilled Pen ☐ Inject 80mg SQ every other week Qty: 2

☐ **Kevzara® (sarilumab) Prefilled Syringe** ☐ Inject 150mg SQ every other week Qty: 2
☐ Inject 200mg SQ every other week Qty: 2 Refills _____

☐ **Olumiant® (baricitinib) Tablet** ☐ 1mg Tablet ☐ 2mg Tablet
Directions: Take 1 tablet daily Qty: 30 Refills _____

☐ **Orencia® (abatacept)** ☐ ClickJect Autoinjector ☐ Prefilled Syringe
Directions: Inject 125mg SQ weekly Qty: 4 Refills _____

☐ **Otezla® (apremilast)** ***TITRATION PACK*** ☐ *Take 1 tablet as directed per titration schedule on packaging* *Qty: 55*
Maintenance Dose ☐ Take 1 tablet (30mg) twice daily as directed Qty: 60 Refills _____

☐ **Rinvoq® (upadacitinib)** 15mg ER Tablet ☐ Take 1 tablet once daily Qty: 30 Refills _____

☐ **Simponi® (golimumab)**
☐ Prefilled Syringe ☐ SmartJect® ☐ Inject 50mg SQ once a month Qty: 1 Refills _____

☐ **Stelara® (ustekinumab)** ***INITIAL DOSE*** ☐ *Inject 45mg SQ on Days 0 & 28* *Qty: 2*
☐ Vial ☐ Prefilled Syringe ***INITIAL DOSE*** ☐ *Inject 90mg SQ on Days 0 & 28* *Qty: 2*
☐ Inject 45mg SQ every 12 weeks Qty: 1
☐ Inject 90mg SQ every 12 weeks Qty: 1

☐ **Xeljanz® (tofacitinib)** 5mg Tablet ☐ Take 1 tablet twice daily Qty: 60
11mg XR Tablet ☐ Take 1 tablet once daily Qty: 30 Refills _____