



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

Eosinophilic Esophagitis (EoE) 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

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

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
 Drug Allergies _____
 Prior Therapy and for how long? _____
 Reason for Discontinuation? _____
 Any other relevant medical info? _____

PRESCRIPTION INFORMATION (DAW requests must be handwritten)

<input type="checkbox"/> Dupixent®	<input type="checkbox"/> Single-Dose Pre-Filled Syringe with Needle Shield	<input type="checkbox"/> Single-Dose Pre-Filled Pen
<input type="checkbox"/> 15 kg to less than 30 kg	<u>Inject 200 mg every other week (Q2W)</u>	Qty: 2 Refills: _____
<input type="checkbox"/> 30 kg to less than 40 kg	<u>Inject 300 mg every other week (Q2W)</u>	Qty: 2 Refills: _____
<input type="checkbox"/> 40 kg or more	<u>Inject 300 mg every week (QW)</u>	Qty: 4 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.