Gentry HEALTH SERVICES
Together Creating a Path to Better Care

Vitiligo Patient Enrollment and 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 __________
Date of Diagnosis ______________ Body Surface Affected: ________ %
Drug Allergies ____________________ Latex Allergy? ☐ YES ☐ NO

Failed Prior therapies?

☐ Topical Corticosteroids:

____________________ __________ to __________
____________________ __________ to __________

☐ Topical therapy not appropriate

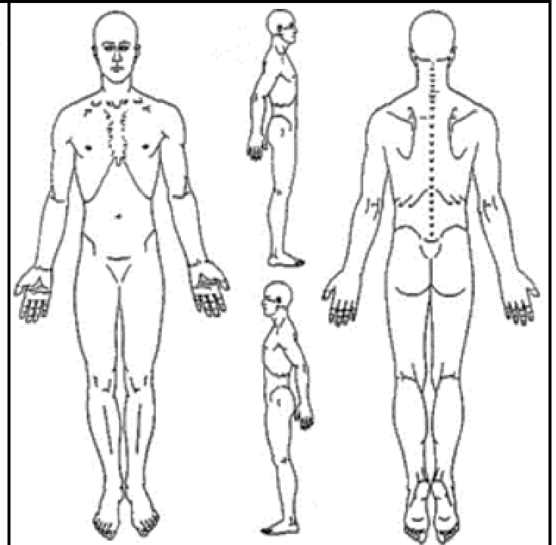
Reason: ____________________

☐ Systemic Corticosteriods, Immunosupressants and/or Phototherapy:

____________________ __________ to __________
____________________ __________ to __________
____________________ __________ to __________

☐ Systemic corticosteroids not appropriate
☐ Immunosuppressants not appropriate
☐ Phototherapy not appropriate

Reason: ____________________



Affected Areas: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Face ☐ Other: ______________

Additional Comments ____________________

PRESCRIPTION INFORMATION

(please indicate days supply if different than suggested days supply)

☐ **OPZELURA™ 1.5% Cream 60 GM Tube**

Directions: Apply thin layer twice daily to affected areas of up to 10% of body surface area.

Quantity: ________ tube(s) Days Supply: ________ Number of 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.