Atopic Dermatitis
Patient Enrollment and Prescription Form

Gentry HEALTH SERVICES
Together Creating a Path to Better Care

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: ________ %

❑ **Patient has moderate to severe atopic dermatitis (AD) that is inadequately controlled on prior or current topical therapy**

Drug Allergies ______________________ Latex Allergy? ❑ YES ❑ NO

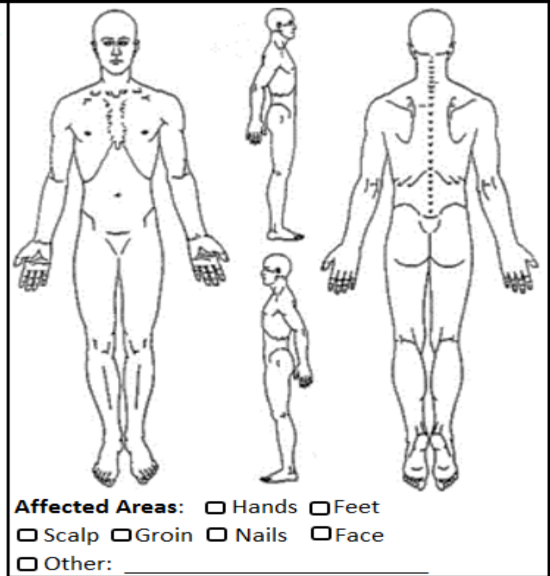
Failed Prior therapies?

❑ 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: ______________

Does the patient have history of conjunctivitis or keratitis? ❑ YES ❑ NO
Additional Comments ______________________

PRESCRIPTION INFORMATION

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

❑ **Adbry® (tralokinumab-ldrm)** ❑ 150mg Pre-filled Syringe ❑ 300 mg Auto-Injector
- ❑ ADULT DOSING: 600MG SQ at week 0 and 300MG every other week Quantity: __________ Refills _____
- ❑ PEDIATRIC DOSING: 300MG at week 0 and 150MG every other week Quantity: __________ Refills _____

❑ **Cibinqo™ (abrocitinib)** ❑ 50mg Tablet ❑ 100 mg Tablet ❑ 200 mg Tablet
Directions: Take 1 tablet daily Qty: 30 tablets Refills __________

❑ **Dupixent® (dupilumab)** ❑ Syringe ❑ Pen
- ❑ ADULT STARTER: 600MG SQ at week 0, 300MG SQ at weeks 2 & 4 Quantity: 4 Refills _____
- ❑ ADULT MAINTENANCE: 300MG SQ once every 2 weeks Quantity: 2 Refills _____
- ❑ PED (up to 5yr): 200MG SQ every 4 weeks Quantity: 2 Refills _____
- ❑ PED (up to 5yr): 300MG SQ every 4 weeks Quantity: 2 Refills _____
- ❑ PED (6-17 yrs) up to 30kg: 600MG SQ week 0, 300mg Q4 weeks Quantity: 2 Refills _____
- ❑ PED (6-17 yrs) up to 60kg: 400MG SQ week 0, 200mg Q2 weeks Quantity: 2 Refills _____
- ❑ PED (6-17 yrs) above 60kg: 600MG SQ week 0, 300mg Q2 weeks Quantity: 2 Refills _____

❑ **OPZELURA™ 1.5% Cream 60 GM Tube**
Directions: Apply thin layer twice daily to affected areas (up to 20% BSA) MAX 60 gm/wk. Qty: ___ tube(s) Refills _____

❑ **Rinvoq® (upadacitinib)** ❑ 15mg ER Tablet ❑ 30mg ER Tablet
Directions: Take 1 tablet daily Qty: 30 tablets 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.