Atopic Dermatitis
Patient Enrollment and Prescription Form

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, Ohio.

P: 1-844-443-6879 F: 1-844-329-2447

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:

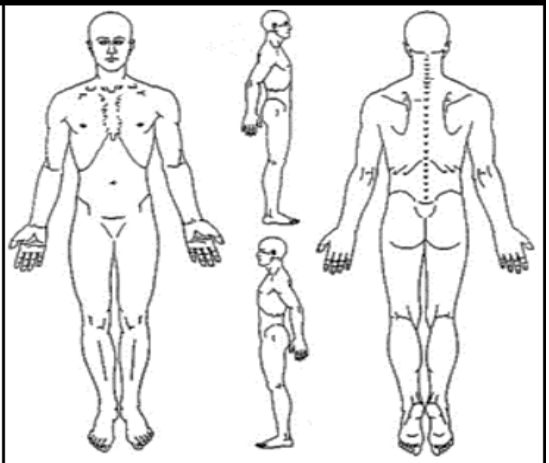
_____ _____ to _____
_____ _____ to _____

☐ 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 _____

☐ **EBGLYSS™ (lebrikizumab-lbkz)** ☐ 250mg/2mL Pre-Filled Syringe ☐ 250mg/2mL Pen
☐ INITIAL DOSE: 500MG SQ at week 0 and week 2 Quantity: _____ Refills _____
☐ INDUCTION DOSE: 250 MG SQ every 2 weeks Quantity: _____ Refills _____
☐ MAINTENANCE DOSE: 250MG SQ every 4 weeks Quantity: _____ 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 _____