Hidradenitis Suppurativa
Patient Enrollment and Prescription Form

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.

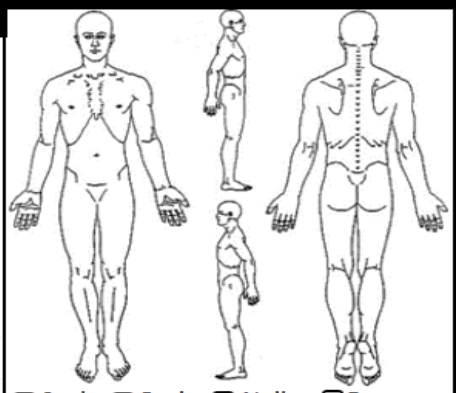
Prescriber Signature _____

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 _____ ICD-10 Code _____
Date of Diagnosis _____ Body Surface Affected: _____ %
TB positive? ☐YES ☐NO If yes, is the patient currently being treated? ☐YES ☐NO
HBV positive? ☐YES ☐NO If yes, is the patient currently being treated? ☐YES ☐NO
Drug Allergies _____ Latex Allergy? ☐YES ☐NO
Failed Prior therapies? ☐DMARDS: _____ Duration: _____
☐Topical: _____ Duration: _____
☐Phototherapy: _____ Duration: _____
☐Specialty Meds: _____ Duration: _____
Does the patient have CHF? ☐YES ☐NO Does the patient have MS? ☐YES ☐NO
Additional Comments _____



☐Scalp ☐Groin ☐Nails ☐Face
☐Other: _____

PRESCRIPTION INFORMATION

☐ **Bimzelx® (bimekizumab-bkzx)** ☐320mg Syringe ☐320mg Pen ☐ **Please check if Starter Dose is NOT needed**
☐ Starter Dosing: 320mg SQ at week 0, 2, 4, 6, 8, 10, 12, 14 and 16 Quantity _____ Refills _____
☐ Maintenance: 320mg SQ every 4 weeks Quantity _____ Refills _____

☐ **Cosentyx® (secukinumab)** ☐Prefilled Syringe ☐Sensoready® Pen ☐UnoReady® Pen
☐ 300MG SQ at weeks 0, 1, 2, 3, & 4 then every 4 weeks Quantity _____ Refills _____
☐ 300MG SQ at weeks 0, 1, 2, 3, & 4 then every 2 weeks Quantity _____ Refills _____

☐ **adalimumab** ☐ Prefilled Syringe ☐ Prefilled Pen ☐ **Please check if Starter Dose is NOT needed**
Preferred Brand Name (if required must write DAW): _____
☐ 40mg Dose: 160mg SQ Day 1, then 80mg on Day 15 then 40mg SQ once weekly Quantity _____ Refills _____
☐ 80mg Dose: 160mg SQ Day 1, 80mg Day 15 then 80mg SQ every other week Quantity _____ Refills _____