Crohn's Disease / Ulcerative Colitis

Patient Enrollment & 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 _____ Date of Diagnosis _____
ICD-10 Code: _____ New to therapy? ☐ YES ☐ NO
TB negative? ☐ YES ☐ NO Hepatitis B negative? ☐ YES ☐ NO
Drug Allergies _____ Latex Allergy? ☐ YES ☐ NO
Prior Therapy and for how long? _____
Reason for Discontinuation? _____
Any other relevant medical info? _____

PRESCRIPTION INFORMATION *(DAW requests must be handwritten)*

☐ **Cimzia® (certolizumab)** ☐ 200mg/1ml Prefilled Syringe Starter Kit
Directions: Inject 400 mg SQ initially and at Weeks 2 and 4 Qty: 6 Refills 0
☐ 200mg/1ml Prefilled Syringe for Maintenance Dosing
Directions: ☐ Inject 400 mg SQ every 4 wks **OR** ☐ Inject 400 mg SQ every 2 wks Qty: QS 30 Days Refills _____

☐ **adalimumab** **Preferred Brand Name** (if required must write DAW): _____
☐ Crohn's 40mg Starter Package
Directions: Inject 160 mg SQ initially followed by 80mg two weeks later (Day 15) Qty: 1 KIT Refills 0
☐ 40mg Prefilled Pen Carton for Maintenance Dosing
Directions: Inject 40mg every other week Qty: QS 30 Days Refills _____

☐ **ENTYVIO® (vedolizumab)** 108mg/0.68mL Pen Qty: 2 Pens Refills _____
Directions: Inject 108mg subcutaneously every 2 weeks

☐ **infliximab** 100mg/20ml Vial Qty: QS 30 Days Refills _____
Directions: ☐ Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks **OR** ☐ Infuse 10mg/kg at 0, 2 and 6 weeks, then every 8 weeks

☐ **OMVOH® (mirikizumab)** ☐ INDUCTION DOSE ☐ 300 mg via I.V. at Week 0, Week 4, and Week 8 Qty: 1 vial Refills zero
☐ MAINTENANCE DOSE ☐ 200mg SQ at Week 12 & every 4 weeks thereafter Qty: 2 PFS Refills _____
(given as two consecutive injections of 100 mg each)

☐ **Rinvoq® (upadacitinib)** ☐ INDUCTION DOSE ☐ Take one 45mg tab once daily for 8 weeks Qty: 28 Refills one
☐ MAINTENANCE DOSE ☐ Take one 15mg tablet once daily Qty: 30 Refills _____
☐ Take one 30mg tablet once daily Qty: 30 Refills _____

☐ **Simponi® (golimumab)** TYPE: ☐ Smartject® Autoinjector ☐ Prefilled Syringe STRENGTH: ☐ 100mg
Directions: Inj 200 mg SQ initially at Week 0, followed by 100 mg at Week 2, then 100 mg every 4 weeks Qty: QS 30 Days Refills _____

☐ **Skyrizi® (risankizumab-rzaa)** ☐600 mg single-dose vial - induction ☐180mg single dose cartridge ☐360mg single dose cartridge
☐ INITIATION: Infuse 600 mg as initial IV dose at Week 0, Week 4, and Week 8 ☐ Qty: 60 Days
☐ MAINTENANCE: 180 mg by SQ injection at week 12, and every 8 weeks thereafter ☐ Qty: 60 Days Refills _____
☐ MAINTENANCE: 360 mg by SQ injection at week 12, and every 8 weeks thereafter ☐ Qty: 60 Days Refills _____

☐ **Stelara® (ustekinumab)** ☐130mg Single Dose Vial ☐90mg single-dose prefilled syringe
☐ 260mg Starter (up to 55kg): Infuse intravenously over a period of at least one hour as directed
☐ 390mg Starter (greater than 55kg to 85kg): Infuse intravenously over a period of at least one hour as directed
☐ 520mg Starter (greater than 85mg): Infuse intravenously over a period of at least one hour as directed
☐ MAINTENANCE: Inject 90mg SQ every 8 weeks after initial intravenous dose 60 Days Supply? ☐YES ☐NO Refills _____

☐ **Xeljanz® (tofacitinib)** ☐ INDUCTION DOSE ☐ Take one 10mg tab twice daily for 8 weeks Qty: 120
☐ Take one 22mg XR tab once daily for 8 weeks Qty: 30
☐ MAINTENANCE DOSE ☐ Take one 5mg tablet twice daily Qty: 60 Refills _____
☐ Take one 10mg tablet twice daily Qty: 60 Refills _____
☐ Take one 11mg XR tablet once daily Qty: 30 Refills _____
☐ Take one 22mg XR tablet once daily Qty: 30 Refills _____

☐ **Zeposia® (ozanimod)** ☐ 7 Day Starter ☐ 0.92mg Capsule
☐ INDUCTION DOSE: Take 0.23 mg once daily for days 1-4, then take 0.46 mg once daily for days 5-7 Qty: 1 Pack
☐ MAINTENANCE DOSE: Take 0.92 mg once daily Qty: 30 Refills _____