Asthma

Patient Enrollment & 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: _____ Years since diagnosed: _____

Number of severe exacerbations in the past 12 months: _____

☐ Patient has moderate-to-severe asthma that requires add-on maintenance treatment ☐ Atopic comorbidities

Eosinophil levels (if available)_____ cells/mcL Test date_____

IgE level (if available)_____ Test date_____

***Please attach the patient's most recent CBC with differential

Drug Allergies: _____ Latex Allergy? ☐YES ☐NO

Other Disease States or Comorbidities _____

Current Asthma Regimen

Therapy Type	Drug Name	Duration
☐Bronchodilator Therapy		to
☐Inhaled Corticosteroid		to
☐Combination Therapy		to
☐Oral Corticosteroid		to
☐Other		to
☐Other		to

PRESCRIPTION INFORMATION

☐ **Dupixent® (dupilumab)** ☐ 300 mg/2 mL Pre-filled Syringe ☐ 300 mg/2 mL Pre-filled Pen

☐ STARTER DOSE: 600MG SQ at week 0, 300MG SQ at weeks 2 & 4 Quantity: 4 Syringes Refills _____

☐ MAINTENANCE DOSE: 300MG SQ once every 2 weeks Quantity: 2 Syringes Refills _____

☐ **Dupixent® (dupilumab)** ☐ 300 mg/2 mL Pre-filled Syringe ☐ 300 mg/2 mL Pre-filled Pen

☐ STARTER DOSE: 600MG SQ at week 0, 300MG SQ q4weeks Quantity: 2 Syringes Refills _____

☐ MAINTENANCE DOSE: 300MG SQ once every 4 weeks Quantity: 2 Syringes Refills _____

☐ **Dupixent® (dupilumab)** ☐ 200 mg/1.14 mL Pre-filled Syringe ☐ 200 mg/1.14 mL Pre-filled Pen

☐ STARTER DOSE: 400MG SQ at week 0, 200MG SQ at weeks 2 & 4 Quantity: 4 Syringes Refills _____

☐ MAINTENANCE DOSE: 200MG SQ once every 2 weeks Quantity: 2 Syringes Refills _____

☐ **XOLAIR® (omalizumab)** ☐ Pre-filled Syringe ☐ Autoinjector

☐ 75mg ☐ 150mg ☐ 300mg

☐ 2 week dosing: Inject subcutaneously every two weeks Quantity: _____ Refills _____

☐ 4 week dosing: Inject subcutaneously every four weeks Quantity: _____ Refills _____