Urticaria
Patient Enrollment and Prescription

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

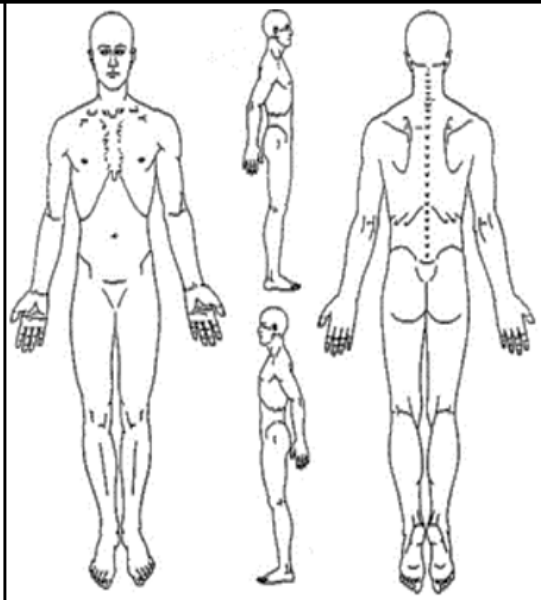
PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis _____ ICD-10 Code _____
Date of Diagnosis _____ Body Surface Affected: _____ %
☐ Itch NRS (0 -10): _____
☐ **Urticaria symptoms persistent more than 6 weeks?**
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 _____
☐ Systemic corticosteroids not appropriate
☐ Oral H1 antihistamines
☐ Immunosuppressants not appropriate
☐ Phototherapy not appropriate
Reason: _____



☐ Scalp ☐ Groin ☐ Face
☐ Other: _____

Additional Comments _____

PRESCRIPTION INFORMATION

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

☐ **Dupixent® (dupilumab)** ☐ Syringe ☐ Pen
☐ ADULT STARTER: 600MG SQ at week 0, 300MG SQ Q2 weeks Quantity: 4 Refills _____
☐ ADULT MAINTENANCE: 300MG SQ once every 2 weeks Quantity: 2 Refills _____
☐ PED (12-17 yrs) 30-59kg: 400MG SQ week 0, 200mg Q2 weeks Quantity: 2 Refills _____
☐ PED (12-17 yrs) ≥60kg: 600MG SQ week 0, 300mg Q2 weeks Quantity: 2 Refills _____

☐ **Rhapsido® (remibrutinib)** ☐ 25mg Tablet
Directions: Take 1 tablet twice daily Qty: 60 tablets Refills _____

☐ **XOLAIR® (omalizumab)** ☐ Pre-filled Syringe ☐ Autoinjector
☐ 75mg ☐ 150mg ☐ 300mg
☐ 4 week dosing: Inject subcutaneously every four weeks Quantity: _____ Refills _____