Psoriasis
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.

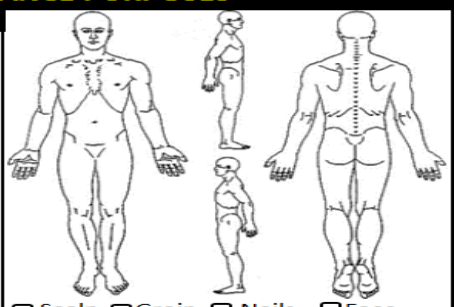
Prescriber Signature _____

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)** ☐ 160mg/ml ☐ 320mg/2ml ☐ Autoinjector ☐ Syringe
☐ Directions: 320mg SQ Week 0, 4, 8, 12, 16, and then every 8 weeks thereafter Quantity _____ Refills _____
☐ Directions: 320mg SQ Week 0, 4, 8, 12, 16, and then every 4 weeks thereafter Quantity _____ Refills _____

☐ **Cimzia® (certolizumab)** ☐ 200mg/1ml Kit ☐ 200mg/1ml Prefilled Syringe
Directions: 400mg SQ every other week Quantity _____ Refills _____

☐ **Cosentyx® (secukinumab)** ☐Prefilled Syringe ☐Sensoready® Pen ☐UnoReady® Pen
Directions: 300MG SQ at weeks 0, 1, 2, 3, & 4 then q4weeks Quantity _____ Refills _____

☐ **Enbrel® (entanercept)** ☐ 25mg Vial ☐ Prefilled Syringe ☐ 50mg SureClick ☐ 50mg Mini Prefilled Cartridge
☐ Directions: Inject 50mg SQ once weekly Quantity _____ Refills _____
☐ Directions: Inject 50mg SQ twice weekly Quantity _____ Refills _____
☐ Directions: Inject 25mg SQ twice weekly Quantity _____ Refills _____

☐ **adalimumab** ☐ Prefilled Syringe ☐ Prefilled Pen ☐ **Please check if Starter Dose is NOT needed**
Preferred Brand Name (if required must write DAW): _____
☐ Psoriasis: 80mg SQ Day 1, 40mg SQ Day 8 and 22 then 40mg SQ every other week Quantity _____ Refills _____

☐ **Icotyde™ (icotrokinra) 200mg Tablet**
Directions: Take 1 tablet daily on an empty stomach with water upon waking Quantity _____ Refills _____

☐ **Otezla® (apremilast)** ☐ 20mg Tab ☐ 30mg Tab ☐ XR 75mg Tab ☐ **Please check if Starter Dose is NOT needed**
XR Directions: Take starter dose as directed then take one tab once daily Quantity _____ Refills _____
IR Directions: Take starter dose as directed then take one tab twice daily Quantity _____ Refills _____

☐ **Siliq™ (brodalumab)** ☐ 210mg Prefilled Syringe ☐ **Please check if Starter Dose is NOT needed**
Directions: Inject 210mg SQ on week 0, 1 and 2 then every 2 weeks thereafter Quantity _____ Refills _____

☐ **Skyrizi™ (risankizumab-rzaa)** ☐ 150mg Syringe ☐ 150mg Pen ☐ **Please check if Starter Dose is NOT needed**
Directions: Inject 150mg SQ on Day 0 and Day 28 then every 12 weeks Quantity _____ Refills _____

☐ **SOTYKTU™ (deucravacitinib) 6mg Tablet**
Directions: Take 1 tablet daily with or without food Quantity _____ Refills _____

☐ **Stelara® (ustekinumab) Prefilled Syringe** ☐ 45mg☐ 90mg ☐ **Please check if Starter Dose is NOT needed**
Directions: Inject 1 syringe SQ on Day 0 and Day 28 then every 12 weeks Quantity _____ Refills _____

☐ **Taltz® (ixekizumab)** ☐ Prefilled Syringe ☐ Autoinjector ☐ **Please check if Starter Dose is NOT needed**
Directions: 160mg week 0, 80mg weeks 2, 4,6, 8, 10 & 12, then 80mg q4weeks Quantity _____ Refills _____

☐ **Tremfya™ (guselkumab)** ☐ 100mg Syringe ☐ 100 mg One-Press ☐ **Please check if Starter Dose is NOT needed**
Directions: Inject 100mg SQ at weeks 0, 4, and every 8 weeks thereafter Quantity _____ Refills _____

☐ **VTAMA® (tapinarof) cream 60 gram tube**
Directions: Apply a thin layer of VTAMA cream to affected areas once daily Quantity _____ Tube(s) Refills _____