



Psoriatic Arthritis

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: _____ Date of Diagnosis _____ ICD-10 Code: _____
 Has a TB test been performed? YES NO If yes, is the patient currently being treated? YES NO
 Has patient been evaluated for HBV? YES NO If positive, is the patient currently being treated? YES NO
 Does the patient have any other health conditions? YES NO If yes: _____
 Drug Allergies _____ Latex Allergy? YES NO
 Prior DMARD usage and for how long? _____

PRESCRIPTION INFORMATION

Bimzelx® (bimekizumab) 160mg/ml 320mg/2ml Autoinjector Syringe
 Directions: 160mg SQ every 4 weeks Quantity _____ Refills _____
 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 Day 0, 14, and 28, then 200mg every other week Quantity _____ Refills _____

Cosentyx® (secukinumab) Prefilled Syringe Sensoready® Pen UnoReady® Pen
 Directions: 150MG SQ at weeks 0, 1, 2, 3, & 4 then q4weeks Quantity _____ Refills _____

Enbrel® (etanercept) 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): _____
 Directions: 40mg SQ every other week 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 _____

Rinvoq® (upadacitinib) 15mg Tablet
 Directions: Take 1 tablet daily as directed Quantity _____ Refills _____

Simponi® (golimumab) 50mg/0.5ml Prefilled Syringe 50mg/0.5ml Smartject Autoinjector
 Directions: Inject 50mg SQ once monthly 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, 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 _____

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.