

Atopic Dermatitis & Prurigo Nodularis

Patient Enrollment and Prescription

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 _____

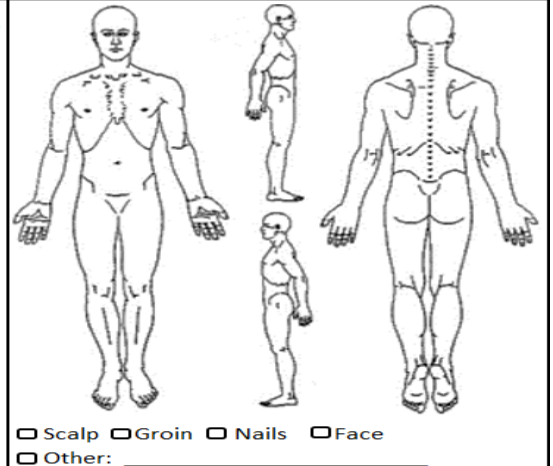
PRESCRIBER INFORMATION

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: _____ %
 # of Nodules: ☐ ≥ 20 Itch NRS (0-10): _____
☐ Patient has moderate to severe atopic dermatitis (AD) that is inadequately controlled on prior or current topical therapy
 Drug Allergies _____ Latex Allergy? ☐ YES ☐ NO
 Failed Prior therapies?
☐ Topical Corticosteroids: _____ to _____
☐ Topical therapy not appropriate
 Reason: _____
☐ Systemic Corticosteroids, Immunosuppressants and/or Phototherapy: _____ to _____
☐ Systemic corticosteroids not appropriate
☐ Immunosuppressants not appropriate
☐ Phototherapy not appropriate
 Reason: _____
 Does the patient have history of conjunctivitis or keratitis? ☐ YES ☐ NO
 Additional Comments _____



PRESCRIPTION INFORMATION

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

☐ Adbry® (tralokinumab-ldrm) ☐ 150mg Pre-filled Syringe ☐ 300 mg Auto-Injector ☐ ADULT DOSING: 600MG SQ at week 0 and 300MG every other week Quantity: _____ Refills _____ ☐ PEDIATRIC DOSING: 300MG at week 0 and 150MG every other week Quantity: _____ Refills _____		
☐ Cibinqo™ (abrocitinib) ☐ 50mg Tablet ☐ 100 mg Tablet ☐ 200 mg Tablet Directions: Take 1 tablet daily Qty: 30 tablets Refills _____		
☐ Dupixent® (dupilumab) ☐ Syringe ☐ Pen ☐ ADULT STARTER: 600MG SQ at week 0, 300MG SQ at weeks 2 & 4 Quantity: _____ Refills _____ ☐ ADULT MAINTENANCE: 300MG SQ once every 2 weeks Quantity: _____ Refills _____ ☐ PED (up to 5yr) 5-14kg: 200MG SQ every 4 weeks Quantity: _____ Refills _____ ☐ PED (up to 5yr) 15-29kg: 300MG SQ every 4 weeks Quantity: _____ Refills _____ ☐ PED (6-17 yrs) 15-29kg: 600MG SQ week 0, 300mg Q4 weeks Quantity: _____ Refills _____ ☐ PED (6-17 yrs) 30-59kg: 400MG SQ week 0, 200mg Q2 weeks Quantity: _____ Refills _____ ☐ PED (6-17 yrs) ≥ 60kg: 600MG SQ week 0, 300mg Q2 weeks Quantity: _____ Refills _____		
☐ EBGLYSS™ (lebrikizumab-ibkz) ☐ 250mg/2mL Pre-Filled Syringe ☐ 250mg/2mL Pen ☐ INITIAL DOSE: 500MG SQ at week 0 and week 2 Quantity: _____ Refills _____ ☐ INDUCTION DOSE: 250 MG SQ every 2 weeks until week 16 Quantity: _____ Refills _____ ☐ MAINTENANCE DOSE: 250MG SQ every 4 weeks Quantity: _____ Refills _____ ☐ ALT. MAINTENANCE DOSE: 250MG SQ every 8 weeks Quantity: _____ Refills _____		
☐ NEMLUVIO® (nemolizumab-ilot) 30mg Prefilled Pen ☐ Prurigo Nodularis < 90kg: 60 mg, followed by 30mg given q4wks Quantity: _____ Refills _____ ☐ Prurigo Nodularis ≥ 90kg: 60 mg, followed by 60mg given q4wks Quantity: _____ Refills _____ ☐ Atopic Dermatitis: 60 mg, followed by 30mg given q4wks Quantity: _____ Refills _____		
☐ OPZELURA™ 1.5% Cream 60 GM Tube Directions: Apply thin layer twice daily to affected areas (up to 20% BSA) MAX 60 gm/wk. Qty: _____ tube(s) Refills _____		
☐ Rinvoq® (upadacitinib) ☐ 15mg ER Tablet ☐ 30mg ER Tablet Directions: Take 1 tablet daily Qty: 30 tablets Refills _____		
☐ VTAMA® (tapinarof) cream 60 gram tube Directions: Apply a thin layer of VTAMA cream to affected areas once daily Quantity: _____ Tube(s) Refills _____		