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Crohn's Disease / Ulcerative Colitis
Patient Enrollment & Prescription Form
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: _____ New to therapy? ☐ YES ☐ NO
TB negative? ☐ YES ☐ NO Hepatitis B negative? ☐ YES ☐ NO
Drug Allergies _____ Latex Allergy? ☐ YES ☐ NO
Prior Therapy and for how long? _____
Reason for Discontinuation? _____
Any other relevant medical info? _____

PRESCRIPTION INFORMATION (DAW requests must be handwritten)

☐ Cimzia® (certolizumab)	☐ 200mg/1ml Prefilled Syringe Starter Kit	Qty: _____	Refills: _____
Directions: <u>Inject 400 mg SQ initially and at Weeks 2 and 4</u>			
	☐ 200mg/1ml Prefilled Syringe for Maintenance Dosing		
Directions: ☐ <u>Inject 400 mg SQ every 4 wks</u> OR ☐ <u>Inject 400 mg SQ every 2 wks</u>		Qty: <u>QS 30 Days</u>	Refills: _____
☐ adalimumab	Preferred Brand Name (if required must write DAW): _____		
☐ Crohn's 40mg Starter Package			
Directions: <u>Inject 160 mg SQ initially followed by 80mg two weeks later (Day 15)</u>		Qty: <u>1 KIT</u>	Refills: <u>0</u>
☐ 40mg Prefilled Pen Carton for Maintenance Dosing			
Directions: <u>Inject 40mg every other week</u>		Qty: <u>QS 30 Days</u>	Refills: _____
☐ ENTYVIO® (vedolizumab)	108mg/0.68mL Pen	Qty: <u>2 Pens</u>	Refills: _____
Directions: <u>Inject 108mg subcutaneously every 2 weeks</u>			
☐ OMVOH® (mirikizumab)	☐ INDUCTION DOSE ☐ 300 mg via I.V. at Week 0, Week 4, and Week 8	Qty: <u>1 vial</u>	Refills: <u>zero</u>
	☐ MAINTENANCE DOSE ☐ <u>200mg SQ at Week 12 & every 4 weeks thereafter</u> (given as two consecutive injections of 100 mg each)	Qty: <u>2 PFS</u>	Refills: _____
☐ Rinvoq® (upadacitinib)	☐ INDUCTION DOSE ☐ Take one 45mg tab once daily for 8 weeks	Qty: <u>28</u>	Refills: <u>one</u>
	☐ MAINTENANCE DOSE ☐ Take one 15mg tablet once daily	Qty: <u>30</u>	Refills: _____
	☐ Take one 30mg tablet once daily	Qty: <u>30</u>	Refills: _____
☐ Simponi® (golimumab)	TYPE: ☐ Smartject® Autoinjector ☐ Prefilled Syringe STRENGTH: ☐ 50mg ☐ 100mg		
☐ 15 - 39kg Dosing & Directions: <u>100 mg SQ initially Week 0, 50 mg at Week 2, then 50 mg every 4 weeks</u>		Qty: <u>QS 30 Days</u>	Refills: _____
☐ ≥ 40kg Dosing & Directions: <u>200 mg SQ initially Week 0, 100 mg at Week 2, then 100 mg every 4 weeks</u>		Qty: <u>QS 30 Days</u>	Refills: _____
☐ Skyrizi® (risankizumab-rzaa)	☐ 600 mg single-dose vial - induction ☐ 180mg single dose cartridge ☐ 360mg single dose cartridge		
☐ INITIATION: <u>Infuse 600 mg as initial IV dose at Week 0, Week 4, and Week 8</u>		☐ Qty: <u>60 Days</u>	
☐ MAINTENANCE: <u>180 mg by SQ injection at week 12, and every 8 weeks thereafter</u>		☐ Qty: <u>60 Days</u>	Refills: _____
☐ MAINTENANCE: <u>360 mg by SQ injection at week 12, and every 8 weeks thereafter</u>		☐ Qty: <u>60 Days</u>	Refills: _____
☐ Stelara® (ustekinumab)	☐ 130mg Single Dose Vial ☐ 90mg single-dose prefilled syringe		
☐ 260mg Starter (up to 55kg): <u>Infuse intravenously over a period of at least one hour as directed</u>			
☐ 390mg Starter (greater than 55kg to 85kg): <u>Infuse intravenously over a period of at least one hour as directed</u>			
☐ 520mg Starter (greater than 85kg): <u>Infuse intravenously over a period of at least one hour as directed</u>			
☐ MAINTENANCE: <u>Inject 90mg SQ every 8 weeks after initial intravenous dose</u>		60 Days Supply? ☐ YES ☐ NO	Refills: _____
☐ Tremfya® (guselkumab)	☐ 100mg Pen ☐ 100mg One-Press Injector ☐ 100mg Prefilled Syringe ☐ 200mg Pen ☐ 200mg Prefilled Syringe		
☐ INITIATION (Crohn's Only): <u>Inject 400mg SQ at Week 0, Week 4 and Week 8</u>		☐ Qty: <u>60 Days</u>	
☐ MAINTENANCE: <u>Inject 100mg SQ at Week 16, and every 8 weeks thereafter</u>		☐ Qty: <u>60 Days</u>	Refills: _____
☐ MAINTENANCE: <u>Inject 200mg SQ at Week 12 and every 4 weeks thereafter</u>		☐ Qty: <u>30 Days</u>	Refills: _____
☐ Xeljanz® (tofacitinib)	☐ INDUCTION DOSE ☐ Take one 10mg tab twice daily for 8 weeks	Qty: <u>120</u>	
	☐ Take one 22mg XR tab once daily for 8 weeks	Qty: <u>30</u>	
	☐ MAINTENANCE DOSE ☐ Take one 5mg tablet twice daily	Qty: <u>60</u>	Refills: _____
	☐ Take one 10mg tablet twice daily	Qty: <u>60</u>	Refills: _____
	☐ Take one 11mg XR tablet once daily	Qty: <u>30</u>	Refills: _____
	☐ Take one 22mg XR tablet once daily	Qty: <u>30</u>	Refills: _____
☐ Zeposia® (ozanimod)	☐ 7 Day Starter ☐ 0.92mg Capsule		
☐ INDUCTION DOSE: <u>Take 0.23 mg once daily for days 1-4, then take 0.46 mg once daily for days 5-7</u>		Qty: <u>1 Pack</u>	
☐ MAINTENANCE DOSE: <u>Take 0.92 mg once daily</u>		Qty: <u>30</u>	Refills: _____

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