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