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/ml Kit
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 _____

☐ **Ilumya® (tildrakizumab-asmn)** ☐ 100mg Syringe ☐ **Please check if Starter Dose is NOT needed**
Directions: Inject 100mg SQ on Day 0 and Day 28 then every 12 weeks 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 ☐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 _____

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