Star Discount Pharmacy
Specialty care

Atopic Dermatitis

Call: (877) 883-1392 Fax: (256) 429-2221

PATIENT INFORMATION

Name: ______________________________ DOB: ______________ Gender: ○ M ○ F Last 4 of SSN: __________

Address: ______________________________________ City: ______________ State: ______ Zip: ________

Phone: ____________________ Alt. Phone: ____________________ Caregiver: ____________________

Email: ____________________ Height: ______ Weight: ______ Allergies: ○ No known ○ See Attached Charts ○ Other: ______

PRESCRIBER INFORMATION

Name: ________________________ NPI: ____________________ DEA # ____________________

Address: ______________________________________ City: ______________ State: ______ Zip: ________

Phone: ____________________ Fax: ____________________ Office Contact: ____________________

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: ______________ **Does Patient Have Latex Allergy:** ○ Yes ○ No **Patient Also Using Topical Steroids:** ○ Yes ○ No

Diagnosis ICD-10: ○ L20.9 ○ Other: ______________ **TB Test:** ○ Positive ○ Negative **Hep B Ruled Out:** ○ Yes ○ No

Assessment: ○ Face ○ Chin ○ Neck ○ Legs ○ Hands ○ Wrists ○ Other: ______________ ○ **ISGA** ○ **EASI** ○ **BSA**

Prior Failed Treatments	Drug Name & Length of Time
○ Topicals	
○ Methotrexate	
○ Oral Meds	
○ Biologics	
○ UVA UVB	
○ Other	

Injection Training	Product Delivery
○ Pharmacist to Provide Training	○ Patients Home
○ Patient Trained in MD Office	○ Physician's Office
○ Manufacturer Nurse Support	○ Pharmacy to Coordinate

PRESCRIPTION INFORMATION (Please be sure to choose both induction and maintenance doses when applicable)

Drug	Strength	Directions	Quantity/Refills
○ **ADBRY**	○ 150mg/mL Prefilled Syringe	○ **Induction Dose:** 600mg (four 150mg injections) subcutaneously on day 1	**Q: 4 R: 0**
		○ **Maintenance Dose:** 300mg (two 150mg injections) subcutaneously every other week starting on day 15.	**Q: 4 R:**
		○ **Adjusted Maintenance Dose:** 300mg (two 150mg injections) subcutaneously every 4 weeks starting after 16 weeks of standard treatment (may be considered in patients <100 kg (220 lbs) who achieve clear or almost clear skin after 16 weeks of treatment).	**Q: 2 R:**
○ **CIBINQO**	○ 50 mg ○ 200 mg ○ 100 mg	○ **SIG:** Take 1 tablet by mouth once daily	**Q: 30 R:**
○ **DUPIXENT**	○ 300mg/2mL Prefilled Syringe ○ 300mg/2mL Prefilled Pen	○ **Induction Dose:** 600mg (two 300mg injections) SQ on Day 1, then inject 300mg every other week starting on Day 15	**Q: 2 R: 0**
		○ **Maintenance Dose:** 300mg SQ every other week	**Q: R:**
○ **RINVOQ**	○ 15 mg tablet ○ 30 mg tablet	○ **SIG:** Take one tablet by mouth once daily	**Q: 30 R:**

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services, and patient assistance programs)

Signature: ______________________________ **Date:** ____________________

Substitution Permitted

Signature: ______________________________ **Date:** ____________________

Dispense as Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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