Star Discount Pharmacy
Specialty care

Pediatric 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	Weight	Directions	Quantity/Refills
○ **DUPIXENT**	○ 300mg/2mL Prefilled Syringe ○ 300mg/2mL Prefilled Pen ○ 200mg/1.14mL Prefilled Syringe ○ 200mg/1.14mL Prefilled Pen		**Patients 6 months – 5 years of age**	
		5 to <15kg	○ ***Initial Dose:*** 200mg SIG: 1 injection SQ on Day 1	Q: 1 R:
			○ ***Maintenance Dose:*** 200mg SIG: 1 injection SQ every 4 weeks, starting on Day 29	Q: R:
		15 to <30kg	○ ***Initial Dose:*** 300mg SIG: 1 injection SQ on Day 1	Q: 1 R:
			○ ***Maintenance Dose:*** 300mg SIG: 1 injection SQ every 4 weeks, starting on Day 29	Q: R:
			Patients 6 years – 17 years of age	
		< 30kg	○ ***Initial Dose:*** Inject 600mg (two 300mg injections) SQ on Day 1	Q: 2 R:
			○ ***Maintenance Dose:*** 300mg SIG: Inject 300 mg every 4 weeks	Q: R:
		30kg to <60kg	○ ***Initial Dose:*** Inject 400mg (two 200mg injections) SQ on Day 1	Q: 2 R:
			○ ***Maintenance Dose:*** 200mg SIG: Inject 200mg every other week	Q: R:
		≥ 60kg	○ ***Initial Dose:*** Inject 600mg (two 300mg injections) SQ on Day 1	Q: 2 R:
			○ ***Maintenance Dose:*** 300mg SIG: Inject 300mg SQ every other week	Q: 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 patients coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected heath information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.