Atopic Dermatitis

Call: (877) 883-1392 Fax: (844) 436-9126

Patient Information: Name:_____ DOB:_____ Gender: M ○ F ○

Address: _____ City:_____ State:_____ Zip: _____
Phone: _____ Alt. Phone: _____ Caregiver: _____
Email: _____ Height: _____ Weight:_____
Allergies: ○ No Known ○ See Attached Charts ○ Other: _____

Please include front and back copies of insurance card.

Prescriber Information

Name: _____ NPI: _____
Address: _____ City: _____ State:_____ Zip:_____
Phone:_____ Fax: _____ Office Contact:_____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis:_____
Primary Diagnosis: ICD-10: ○ L20.9 ○ Other:_____
Assessment: ○ Face ○ Chin ○ Neck ○ Legs ○ Hands ○ Wrists ○ Other _____
○ ISGA ○ EASI ○ BSA _____

Patient also using topical steroids? ○ Yes ○ No
Does patient have latex allergy? ○ Yes ○ No

Prior Failed Treatments — **Indicate Drug Name and Length of Treatment**

- ☐ Topicals _____
- ☐ Methotrexate _____
- ☐ Oral Meds _____
- ☐ Biologic _____
- ☐ UVA ☐ UVB _____
- ☐ Other _____

Injection Training:

- ☐ Pharmacist to Provide Training
- ☐ Patient Trained in MD Office
- ☐ Manufacturer Nurse Support

Product Delivery:

- ☐ Patient's Home
- ☐ Physician's Office
- ☐ Pharmacy to Coordinate

Prescription Information (Please be sure to choose both induction and maintenance dose when applicable)

Drug	Strength	Directions	Quantity & refills
Dupixent	**Adults** ○ 300 mg/2 mL Prefilled Syringe ○ 300mg/2ml Prefilled Pen	○ Induction: Inject 600mg (two-300mg injections) SC on day 1, then inject 300mg every other week starting day 15 ○ Maintenance: Inject 300mg SC every other week	Q: 2 R: 0 Q: R:
	Pediatric ○ 300 mg/2 mL Prefilled Syringe ○ 300mg/2ml Prefilled Pen ○ 200 mg/1.14 mL Prefilled syringe	**< 30 kg** ○ Initial: inject 600mg (two 300 mg injections) SC on day 1 ○ Maintenance: inject 300mg every 4 weeks	Q: 2 R: 0 Q: R:
		30 to < 60kg ○ Initial: inject 400mg (two 200 mg injections) SC on day 1 ○ Maintenance: 200 mg given every other	Q: 2 R: 0 Q: R:
		≥ 60 kg ○ Initial: 600 mg (two 300 mg injections) SC on day 1 ○ Maintenance: 300 mg given every other week	Q: 2 R: 0 Q: R:
Eucrisa	2% Ointment	Apply a thin layer twice daily on affected areas	Q: ○ 60g ○ 100g 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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