

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: _____ Patient also using topical steroids? Yes No
 Primary Diagnosis: ICD-10: L20.9 Other: _____ Does patient have latex allergy? Yes No
 Assessment: Face Chin Neck Legs Hands Wrists Other _____
 ISGA EASI BSA _____

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 <input type="radio"/> 300 mg/2 mL Prefilled Syringe <input type="radio"/> 300mg/2ml Prefilled Pen	<input type="radio"/> Induction: Inject 600mg (two-300mg injections) SC on day 1, then inject 300mg every other week starting day 15 <input type="radio"/> Maintenance: Inject 300mg SC every other week	Q: 2 R: 0 Q: R:
	Pediatric <input type="radio"/> 300 mg/2 mL Prefilled Syringe <input type="radio"/> 300mg/2ml Prefilled Pen	< 30 kg <input type="radio"/> Initial: inject 600mg (two 300 mg injections) SC on day 1 <input type="radio"/> Maintenance: inject 300mg every 4 weeks	Q: 2 R: 0 Q: R:
	<input type="radio"/> 200 mg/1.14 mL Prefilled syringe <input type="radio"/> 200 mg/1.14 mL Prefilled Pen	30 to < 60kg <input type="radio"/> Initial: inject 400mg (two 200 mg injections) SC on day 1 <input type="radio"/> Maintenance: 200 mg given every other	Q: 2 R: 0 Q: R:
		≥ 60 kg <input type="radio"/> Initial: 600 mg (two 300 mg injections) SC on day 1 <input type="radio"/> 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: <input type="radio"/> 60g <input type="radio"/> 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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