



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

Address: _____ City: _____ State: _____ Zip: _____ Last 4 of SSN: _____
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 _____ TB Test: Positive Negative Hep B Ruled Out: Yes No

Prior Failed Treatments

Indicate Drug Name and Length of Treatment

Injection Training:

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

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 and Refills
<input type="radio"/> Cibirgo	<input type="radio"/> 50mg <input type="radio"/> 100mg <input type="radio"/> 200mg	<input type="radio"/> Take 1 tablet by mouth daily	Q: 30 R:
<input type="radio"/> 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:
<input type="radio"/> Eucrisa	<input type="radio"/> 2% Ointment	<input type="radio"/> Apply a thin layer twice daily on affected areas	Q: 60g 100g R:
<input type="radio"/> Rinvoq	<input type="radio"/> 15mg Tablet <input type="radio"/> 30mg Tablet	<input type="radio"/> Take one tablet by mouth 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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