Atopic Dermatitis

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

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

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**

- ◯ 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 and Refills
◯ Cibinqo	◯ 50mg ◯ 100mg ◯ 200mg	◯ Take 1 tablet by mouth daily	Q: 30 R:
◯ Dupixent	**Adults** ◯ 300 mg/2 mL Prefilled Syringe ◯ 300mg/2ml Prefilled Pen	◯ Induction: Inject 600mg (two-300mg injections) SC on day 1, theninject 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 ◯ 200 mg/1.14 mL Prefilled Pen	**< 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:
◯ Opzelura	◯ 1.5% Ointment	◯ Apply a thin layer twice daily on affected areas	Q: 60g R:
◯ Rinvoq	◯ 15mg Tablet ◯ 30mg Tablet	◯ 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.