ATOPIC DERMATITIS SPECIALTY CARE PROGRAM

Phone: **856-963-4742** • Fax: **856-541-8580**

1 PATIENT INFORMATION:

Name: ______________________

Address: ______________________

City: __________ State: ____ Zip: ______

Phone: __________ Alt. Phone: __________

Email: ______________________

DOB: ______ Gender: ❍ M ❍ F Caregiver: ______

Height: ____ Weight: ____ Allergies: ______

2 PRESCRIBER INFORMATION:

Name: ______________________

Address: ______________________

City: __________ State: ____ Zip: ______

Phone: __________ Fax: __________

NPI: __________ DEA: __________

Tax I.D.: ______________________

Office Contact: __________ Phone: __________

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3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: __________ ICD-10: __________

Other: __________ Date: __________

Assessment: ❑ Moderate ❑ Mod to Severe ❑ Severe ____% BSA Affected

❑ Face ❑ Chin ❑ Neck ❑ Legs ❑ Hands ❑ Wrists ❑ Other

Patient also using Topical Steroids? ❑ Yes ❑ No

Does patient have latex allergy? ❑ Yes ❑ No

❑ ISGA or ❑ EASI __________

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Topicals	__________
❑ Methotrexate	__________
❑ Oral Meds	__________
❑ Biologics	__________
❑ UVA ❑ UVB	__________
❑ Others	__________

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If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: ______________________ Patient's Date of Birth: __________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ DUPIXENT®	**For ages 6 years and older** ❑ 300mg/2ml Prefilled Syringe ❑ 200mg/1.14ml Prefilled Syringe ❑ 300mg/2ml Prefilled Pen *(only for 12 years and older)*	❑ **Induction Dose:** ❑ **≥60 kg:** Inject 600mg SC (two 300mg injections) ❑ **30 to <60 kg:** Inject 400mg SC (two 200mg injections) ❑ **15 to <30 kg:** Inject 600mg SC (two 300mg injections)	2	0
		❑ **Maintenance Dose:** ❑ **≥60 kg:** Inject 300mg SC every other week ❑ **30 to <60 kg:** Inject 200mg SC every other week ❑ **15 to <30 kg:** Inject 300mg SC every 4 weeks		
	For Adults ❑ 300mg/2ml Prefilled Syringe ❑ 300mg/2ml Prefilled Pen	❑ **Induction Dose:** ❑ Inject 600mg SC on day one	2	0
		❑ **Maintenance Dose:** ❑ Inject 300mg SC on every other week		
❑ EUCRISA®	❑ 2% Ointment	❑ Apply a thin layer twice daily on affected areas	60g	
			100g	
❑ ______	__________	__________		

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: ______ Signature: __________ Date: ______

Substitution Permitted **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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