



ATOPIC DERMATITIS SPECIALTY CARE PROGRAM

Phone: **888-453-1203** • Fax: **844-786-9706**



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: _____

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

Date of Diagnosis: _____ ICD-10: _____

Other: _____ Date: _____

Assessment: Moderate Mod to Severe Severe

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:

Topicals

Methotrexate

Oral Meds

Biologics

UVA UVB

Others

Indicate Drug Name and Length of Treatment:

If Prior Authorization is Denied: Automatically Draft Appeal for Review Send Preferred Formulary Alternatives

4 INJECTION TRAINING: To Be Administered by Pharmacist Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to 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
<input type="checkbox"/> DUPIXENT®	<input type="checkbox"/> 300mg/2ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 600mg SC on day one	2	0
		<input type="checkbox"/> Maintenance: Inject 300mg SC every 2 weeks	2	
<input type="checkbox"/> EUCRISA®	<input type="checkbox"/> 2% Ointment	<input type="checkbox"/> Apply a thin layer twice daily on affected areas	1	
<input type="checkbox"/> _____	_____	_____		

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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