

# ATOPIC DERMATITIS SPECIALTY CARE PROGRAM

Phone: **888-601-8711** • Fax: **844-436-9128**

## 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:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> Topicals	_____
<input type="checkbox"/> Methotrexate	_____
<input type="checkbox"/> Oral Meds	_____
<input type="checkbox"/> Biologics	_____
<input type="checkbox"/> UVA <input type="checkbox"/> UVB	_____
<input type="checkbox"/> Others	_____

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

## 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
<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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