ATOPIC DERMATITIS SPECIALTY CARE PROGRAM

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 ____% 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 _____

TB Test: ❑ Positive ❑ Negative Date: _____

Pregnancy test: ❑ Positive ❑ Negative Date: _____

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

Does the patient have been assessed for helminth infection? ❑ Yes ❑ No

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
❑ ADBRY™	❑ 150mg/mL single-dose Prefilled Syringe	❑ **Induction Dose:** ❑ Inject 600mg SC (four 150mg injections) on day one	4	
		❑ **Maintenance Dose:** ❑ Inject 300mg SC (two 150mg injections) SC every other week ❑ For <100 Kg: Inject 300mg SC (two 150mg injections) SC every four weeks	4 2	
❑ CIBINQO™	❑ 50mg Oral Tablet ❑ 100mg Oral Tablet ❑ 200mg Oral Tablet	Recommended dosage: ❑ 100mg orally once daily ❑ 200mg orally once daily (who are not responding to 100mg once daily after 12 weeks) **For moderate renal impairment/CYP2C19 poor metabolizer:** ❑ 50mg once daily OR ❑ 100mg once daily	30	
❑ DUPIXENT®	**For ages 6 months and older** ❑ 300mg/2ml single-dose Prefilled Syringe ❑ 200mg/1.14ml single-dose Prefilled Syringe ❑ 100 mg/0.67 mL single-dose Pre-Filled Syringe ❑ 300mg/2ml single-dose Prefilled Pen ❑ 200mg/1.14ml single-dose Prefilled Pen	❑ **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	
		❑ **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 single-dose Prefilled Syringe ❑ 300mg/2ml single-dose Prefilled Pen	❑ **Induction Dose:** ❑ Inject 600mg SC on day one		
		❑ **Maintenance Dose:** ❑ Inject 300mg SC on every other week		
		❑ **Pediatric patients 6 months to 5 years of age:** ❑ 5 to<15kg: 200mg (one 200mg injection) every 4 weeks ❑ 15 to<30kg: 300mg (one 300mg injection) every 4 weeks		
❑ EUCRISA®	❑ 2% Ointment	❑ Apply a thin layer twice daily on affected areas	60g 100g	
❑ OPZELURA™	❑ 12 years of age and older: 1.5%	❑ Apply a thin layer twice daily on affected areas	60g	
❑ RINVOQ® XR	❑ 15mg and 30mg ER Tablet	❑ For pediatric patient ≥12 years of age and weight at least 40 kg and, adult <65 years of age: 15mg orally once daily (If an adequate response is not achieved, consider increasing the dosage to 30mg orally once daily) ❑ For adults ≥65 years of age: 15mg orally once daily	30	
❑ _____	_____	_____		

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.

v10.0_062022