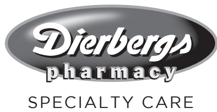

SPECIALTY CARE

ATOPIC DERMATITIS SPECIALTY CARE PROGRAM

Phone: **844-283-6308** • Fax: **844-965-9849**

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: ____________

v9.4_031419

©2017 KloudScript, Inc. - All rights reserved.

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:
❑ Topicals	________
❑ Methotrexate	________
❑ Oral Meds	________
❑ Biologics	________
❑ UVA ❑ UVB	________
❑ Others	________

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®	❑ 300mg/2ml Prefilled Syringe	**For adults and adolescents 12 years of age and older that weigh 132lbs or more:** ❑ **Induction Dose:** Inject 600mg SC on day one	2	0
		❑ **Maintenance:** Inject 300mg SC every other week	2	
	❑ 200mg/1.14ml Prefilled Syringe	**For adolescents 12 years of age and older that weigh less than 132lbs:** ❑ **Induction Dose:** Inject 400mg SC on day one	2	0
		❑ **Maintenance:** Inject 200mg SC every other week	2	
❑ EUCRISA®	❑ 2% Ointment	❑ Apply a thin layer twice daily on affected areas	1	
❑ ________	________	________		

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.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.