ATOPIC DERMATITIS SPECIALTY PROGRAM

Phone: 844-223-7510
Fax: 844-673-6161

PATIENT INFORMATION:

Name: ______________________ Address: ______________________

City: ____________ State: ____ Zip: ________ Phone: ____________ Alt. Phone: ____________

Email: ______________________ DOB: ________ Gender: ______ Height: ______

Weight: ______ Allergies: ______________________

PRESCRIBER INFORMATION:

Name: ______________________ Address: ______________________

City: ____________ State: ____ Zip: ________ Phone: ____________ Fax: ____________

NPI: ____________ DEA: ____________ Tax I.D.: ____________

Office Contact: ____________ Phone with Extension: ____________

STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: ____________ Primary ICD-10: ____________ Secondary ICD-10: ____________

Sensitive Areas Affected: Hands Feet Face & Neck Genitals/Groin Scalp Intertriginous Areas

Other: ____________ BSA involved: ________% Scoring Tool Name & Score: ____________

PRIOR TREATMENTS AND DATES OF THERAPY: ______________________

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REQUIRED INFORMATION: Please fax copy of ***Prescription and Insurance Cards*** (front and back), as well as ***Clinical Chart Notes and Labs/Test Results***

PRESCRIPTION INFORMATION:

Patient Name: ______________________ Date of Birth: ____________

Medication	Strength	Directions	Quantity/Refills
Dupixent (dupilumab)	**200 mg/1.14ml PFS***	Initial Dose: 400mg (2 injections) subcutaneously on Day 1 Maintenance Dose: 200mg (1 injection) subcutaneously every 2 weeks starting on Day 15	Quantity: ______ Refills:________
	300 mg/2mL PFS* ***Come in cartons of 2 PFS**	Initial Dose: 600mg (2 injections) subcutaneously on Day 1 Maintenance Dose: 300mg (1 injection) subcutaneously every 2 weeks starting on Day 15	Quantity: ______ Refills:________

PHYSICIAN SIGNATURE REQUIRED:

SIGNATURE: ______________________ **DATE:** ____________