Atopic Dermatitis Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com
Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax_____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other:_____
Diagnosis (ICD-10):
☐ L20.9 Atopic Dermatitis, Unspecified ☐ Other Code: _____ Description _____
Patient Clinical Information:
Allergies: _____ Weight: _____lb/kg Height: _____in/cm TB Test Result: _____ Date: _____

Atopic Dermatitis Enrollment Form

Please Complete Patient , Prescriber and Patient Clinical Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____

Weight:_____lb/kg Height:_____In/cm TB Test Result: _____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Adbry	☐ Prefilled syringe (2x150 mg/mL) ☐ Prefilled syringe (4x150 mg/mL)	☐ Loading Dose: Inject 600 mg (4x150 mg/mL) subcutaneously on week 0 ☐ Maintenance Dose: Inject 300 mg (2X150 mg/mL) subcutaneously at week 2 and every 2 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Cibinqo	☐ 50 mg ☐ 100 mg ☐ 200 mg	☐ Take 1 tablet by mouth once daily ☐ Other:_____	Quantity: _____ Refills: _____
☐ Dupixent	☐ Carton of two 300 mg/2 mL solution prefilled syringes with needle shield ☐ Carton of two 200 mg/1.14 mL solution in a single-dose prefilled syringe with needle shield ☐ Carton of two 300 mg/2 mL solution in a single-dose pre-filled pen **(for use in adolescents ≥12 years)** ☐ Carton of two 200 mg/1.14 mL solution in a single-dose pre-filled pen **(for use in adolescents ≥12 years)**	**Adult Patients:** ☐ Initial Dose: Inject 600 mg SC (two 300 mg injections in different injection sites) initially, then 300 mg SC every other week ☐ Maintenance Dose: Inject 300 mg (one injection) SC every other week **Pediatric Patients (6 to 17 years of age):** 15 to less than 30 kg: ☐ Initial dose: 600 mg (two 300 mg injections in different injection sites) ☐ Maintenance Dose: 300 mg given every 4 weeks 30 to less than 60 kg: ☐ Initial dose: 400 mg (two 200 mg injections in different injection sites) ☐ Maintenance Dose: 200 mg given every other week 60 kg or more: ☐ Initial dose: 600 mg (two 300 mg injections in different injection sites) ☐ Maintenance Dose: 300 mg given every other week ☐ Other: _____	Quantity: _____ Refills: _____
☐ Rinvoq	☐ 15 mg ☐ 30 mg	☐ Take 1 tablet by mouth once daily ☐ Other:_____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____ Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____ Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.