

# Atopic Dermatitis Enrollment Form



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
<input type="checkbox"/> Adbry	<input type="checkbox"/> Prefilled syringe (2x150 mg/mL) <input type="checkbox"/> Prefilled syringe (4x150 mg/mL)	<input type="checkbox"/> <u>Loading Dose:</u> Inject 600 mg (4x150 mg/mL) subcutaneously on week 0 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 300 mg (2X150 mg/mL) subcutaneously at week 2 and every 2 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cibinqo	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Dupixent	<input type="checkbox"/> Carton of two 300 mg/2 mL solution prefilled syringes with needle shield  <input type="checkbox"/> Carton of two 200 mg/1.14 mL solution in a single-dose prefilled syringe with needle shield  <input type="checkbox"/> Carton of two 300 mg/2 mL solution in a single-dose pre-filled pen <b>(for use in adolescents ≥12 years)</b>  <input type="checkbox"/> Carton of two 200 mg/1.14 mL solution in a single-dose pre-filled pen <b>(for use in adolescents ≥12 years)</b>	<b>Adult Patients:</b> <input type="checkbox"/> Initial Dose: Inject 600 mg SC (two 300 mg injections in different injection sites) initially, then 300 mg SC every other week <input type="checkbox"/> Maintenance Dose: Inject 300 mg (one injection) SC every other week <b>Pediatric Patients (6 to 17 years of age):</b> <u>15 to less than 30 kg:</u> <input type="checkbox"/> Initial dose: 600 mg (two 300 mg injections in different injection sites) <input type="checkbox"/> Maintenance Dose: 300 mg given every 4 weeks <u>30 to less than 60 kg:</u> <input type="checkbox"/> Initial dose: 400 mg (two 200 mg injections in different injection sites) <input type="checkbox"/> Maintenance Dose: 200 mg given every other week <u>60 kg or more:</u> <input type="checkbox"/> Initial dose: 600 mg (two 300 mg injections in different injection sites) <input type="checkbox"/> Maintenance Dose: 300 mg given every other week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg	<input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other:	<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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.

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