Atopic Dermatitis Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____ _____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

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: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Adbry	☐ 2 x 150 mg/mL PFS ☐ 4 x 150 mg/mL PFS ☐ 1 x 300 mg/2 mL PEN ☐ 2 x 300 mg/2 mL PEN	Adult Loading Dose: ☐ Inject 600 mg (4 x 150 mg/mL pre-filled syringes) SC on Day 1 ☐ Inject 600 mg (2 x 300 mg/2 mL PEN) SC on Day 1	Quantity: ☐ 4 x 150 mg/mL PFS ☐ 2 x 300 mg/2 mL PEN Refills: 0
		Adult Maintenance Dose: ☐ Inject 300 mg SC every other week Adult Maintenance Dose (After Week 16, if patient achieves clear or almost clear skin and weighs < 100 kg): ☐ Inject 300 mg SC every 4 weeks	Quantity: ☐ 28 days ☐ 84 days Refills: _____
		Pediatric Loading Dose (≥12 y/o): ☐ Inject 300 mg (2 x 150 mg/mL pre-filled syringes) SC Day 1	Quantity: ☐ 2 x 150 mg/mL PFS Refills: 0
		Pediatric Maintenance Dose (≥12 y/o): ☐ Inject 150 mg (1 x 150 mg/mL pre-filled syringe) SC every other week	Quantity: ☐ 2 x 150 mg/mL PFS ☐ 28 days ☐ 84 days Refills: _____
☐ Cibinqo	☐ 50 mg ☐ 100 mg ☐ 200 mg	☐ Take 1 tablet by mouth once daily ☐ Other:_____	Quantity: _____ Refills: _____

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.

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Please Complete Patient , Prescriber and Patient Clinical Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Patient Address: _____

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
☐ Dupixent	**For use in patients ≥ 6 months and older:** ☐ 200 mg/1.14 mL (Carton of two pre-filled syringes with needle shield) ☐ 300 mg/2 mL (Carton of two pre-filled syringes with needle shield) **For use in patients ≥ 2 years of age and older:** ☐ 200 mg/1.14 mL (Carton of two single dose pre-filled pens) ☐ 300 mg/2 mL (Carton of two single dose pre-filled pens)	**Adult Patients:** ☐ 600 mg (two 300 mg injections) subcutaneously on Day 1, then 300 mg subcutaneously every other week thereafter **Pediatric Patients (6 months to 5 years of age):** 5 to less than 15 kg: ☐ 200 mg (one pre-filled syringe) every 4 weeks 15 to less than 30 kg: ☐ 300 mg (one pre-filled syringe) every 4 weeks **Pediatric Patients (6 years to 17 years of age)** 15 to less than 30 kg: ☐ 600 mg (two 300 mg injections) subcutaneously on Day 1, then 300 mg subcutaneously every 4 weeks thereafter 30 to less than 60 kg: ☐ 400 mg (two 200 mg injections) subcutaneously on Day 1, then 200 mg subcutaneously every 2 weeks thereafter 60 kg or more: ☐ 600 mg (two 300 mg injections) subcutaneously on Day 1, then 300 mg subcutaneously every 2 weeks thereafter	Quantity: _____ (# of injections) Refills: _____
☐ Ebglyss	☐ 250 mg/2 mL PEN ☐ 250 mg/2 mL PFS	**Induction Dose (≥ 12 y/o who weigh ≥ 40 kg)** ☐ Week 0 and 2: Inject 500 mg (two 250 mg injections) SC every 2 weeks ☐ Week 4-14: Inject 250 mg (one injection) SC every 2 weeks **Maintenance Dose (Week 16 or later, when adequate clinical response is achieved):** ☐ Inject 250 mg SC every 4 weeks	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Nemluvio	☐ 30 mg/0.49 mL PEN	**Induction Dose:** ☐ Inject 60 mg (two 30 mg injections) SC followed by 30 mg given every 4 weeks	Quantity: 28 DS Refills: 0
		Maintenance Dose: ☐ Inject 30 mg SC every 4 weeks **(After 16 weeks of treatment, for patients who achieve clear or almost clear skin):** ☐ Inject 30 mg SC every 8 weeks	Quantity: 28 DS Refills: _____ Quantity: 56 DS 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

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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.