



ATOPIC DERMATITIS ALOPECIA

Phone: 855.257.2584 || Fax: 866.680.3539

Date _____

Ship to: Patient Provider

NEW START Continuation

PATIENT INFORMATION

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth: / /		Office FAX:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS (ICD-10) L20. ___ Atopic Dermatitis L63. ___ Alopecia

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION

Tried/Failed Therapies Topical Steroids: _____
 Adbry Cibinqo Dupixent Elidel Eucrisa Olumiant Protopic Rinvoq Xeljanz

BSA: _____% Hands Feet Scalp Groin Other Areas _____

PPD/Chest X-Ray for TB? Yes No Drug Allergies: _____

PRESCRIPTION INFORMATION

<input type="checkbox"/> Adbry	<input type="checkbox"/> 150mg Syringe	<input type="checkbox"/> Start: Inject 600mg Simultaneously on Day 1 (qty 4 / 14 days) <input type="checkbox"/> Maint: Inject 300mg every other week (qty 4 / 28 days) *Pt. weight ___ lbs	Refill: 0 Refill:
<input type="checkbox"/> Cibinqo	<input type="checkbox"/> 50mg Tablet <input type="checkbox"/> 100mg Tablet <input type="checkbox"/> 200mg Tablet	<input type="checkbox"/> Take ___mg tablet by mouth once daily. *Pt. weight ___ lbs	Refill:
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 200mg Syringe <input type="checkbox"/> 300mg Syringe <input type="checkbox"/> 300mg PEN	<input type="checkbox"/> Start: Inject ___mg on day 0 <input type="checkbox"/> Maint: Inject ___mg every ___ week(s) *Pt. weight ___ lbs	Refill: 0 Refill:
<input type="checkbox"/> Olumiant	<input type="checkbox"/> 1mg Tablet <input type="checkbox"/> 2mg Tablet <input type="checkbox"/> 4mg Tablet	<input type="checkbox"/> Take ___mg tablet by mouth once daily. *Pt. weight ___ lbs	Refill:
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg Tablet <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Take ___mg tablet by mouth once daily. *Pt. weight ___ lbs	Refill: 0
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg Tablet <input type="checkbox"/> 10mg Tablet	<input type="checkbox"/> Take ___mg tablet by mouth once daily. *Pt. weight ___ lbs	Refill:

PRESCRIBER SIGNATURE _____ DATE ___ / ___ / ___

PRODUCT SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN