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:	☐ M ☐ 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

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

PRESCRIBER SIGNATURE ______________________________ ______________________________ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN