

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____
 Other: _____ Date: _____
 Assessment: Moderate Mod to Severe Severe _____% BSA Affected
 Face Chin Neck Legs Hands Wrists Other
 Patient also using Topical Steroids? Yes No
 Does patient have latex allergy? Yes No
 ISGA or EASI _____
 TB Test: Positive Negative Date: _____
 Pregnancy test: Positive Negative Date: _____

Prior Failed Treatments:
 Topicals
 Methotrexate
 Oral Meds
 Biologics
 UVA UVB
 Others
 Does the patient have been assessed for helminth infection? Yes No

Indicate Drug Name and Length of Treatment:

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: To Be Administered by Pharmacist (State of Missouri Only) Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> ADBRY™	<input type="checkbox"/> 150mg/mL single-dose Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 600mg SC (four 150mg injections) on day one <input type="checkbox"/> Maintenance Dose: Inject 300mg SC (two 150mg injections) SC every other week For <100 Kg: Inject 300mg SC (two 150mg injections) SC every four weeks	4 4 2	
<input type="checkbox"/> CIBINQO™	<input type="checkbox"/> 50mg Oral Tablet <input type="checkbox"/> 100mg Oral Tablet <input type="checkbox"/> 200mg Oral Tablet	Recommended dosage: <input type="checkbox"/> 100mg orally once daily <input type="checkbox"/> 200mg orally once daily (who are not responding to 100mg once daily after 12 weeks) For moderate or mild renal impairment/CYP2C19 poor metabolizer: <input type="checkbox"/> 50mg once daily OR <input type="checkbox"/> 100mg once daily	30	
<input type="checkbox"/> DUPIXENT®	For Pediatric <input type="checkbox"/> 300mg/2ml single-dose Prefilled Syringe <input type="checkbox"/> 200mg/1.14ml single-dose Prefilled Syringe <input type="checkbox"/> 100 mg/0.67 mL single-dose Pre-Filled Syringe <input type="checkbox"/> 300mg/2ml single-dose Prefilled Pen <input type="checkbox"/> 200mg/1.14ml single-dose Prefilled Pen For Adults <input type="checkbox"/> 300mg/2ml single-dose Prefilled Syringe <input type="checkbox"/> 300mg/2ml single-dose Prefilled Pen	For Ages 6 years and older: <input type="checkbox"/> Induction Dose: <input type="checkbox"/> ≥60 kg: Inject 600mg SC (two 300mg injections) <input type="checkbox"/> 30 to <60 kg: Inject 400mg SC (two 200mg injections) <input type="checkbox"/> 15 to <30 kg: Inject 600mg SC (two 300mg injections) <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> ≥60 kg: Inject 300mg SC every other week <input type="checkbox"/> 30 to <60 kg: Inject 200mg SC every other week <input type="checkbox"/> 15 to <30 kg: Inject 300mg SC every 4 weeks <input type="checkbox"/> Pediatric patients 6 months to 5 years of age: <input type="checkbox"/> 5 to<15kg: 200mg (one 200mg injection) every 4 weeks <input type="checkbox"/> 15 to<30kg: 300mg (one 300mg injection) every 4 weeks For Adults <input type="checkbox"/> Induction Dose: Inject 600mg SC on day one <input type="checkbox"/> Maintenance Dose: Inject 300mg SC on every other week	2	
<input type="checkbox"/> EUCRISA®	<input type="checkbox"/> 2% Ointment	<input type="checkbox"/> Apply a thin layer twice daily on affected areas	60g 100g	
<input type="checkbox"/> OPZELURA™	<input type="checkbox"/> 12 years of age and older: 1.5%	<input type="checkbox"/> Apply a thin layer twice daily on affected areas	60g	
<input type="checkbox"/> RINVOQ® XR	<input type="checkbox"/> 15mg and 30mg ER Tablet	<input type="checkbox"/> For pediatric patient ≥12 years of age and weight at least 40 kg and, adult <65 years of age: 15mg orally once daily (If an adequate response is not achieved, consider increasing the dosage to 30mg orally once daily) <input type="checkbox"/> For adults ≥65 years of age: 15mg orally once daily	30	
<input type="checkbox"/>				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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