V.07.18.17.A

Atopic Dermatitis Referral Form

Referral for Medication and Patient Management Program

Phone: 877 385 0535 Fax: 877 326 2856

OptiMed SPECIALTY PHARMACY

Patient Demographics

Name: _____ ☐M ☐F

DOB: _____ SS#: _____

Phone: _____ 2nd Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary language, if other than English: _____

****Please fax a copy (front and back) of the patient's insurance card as well as any relevant clinical notes/documents****

Provider Information

Prescriber: _____

_____

Phone: _____ Fax: _____

Address: _____

_____

NPI: _____ Office contact: _____

This is a: ☐New Rx ☐Refill

Training by: ☐Prescriber's office ☐Pharmacy to facilitate ☐Not needed

Deliver first fill to: ☐Prescriber's office ☐Patient ☐Other: _____

Clinical Information

Diagnosis:

☐ Atopic dermatitis (L20._____)

☐ Atopic dermatitis, unspecified (L20.9)

☐ Other: _____

Patient weight: _____ Height: _____ Allergies: _____

BSA affected (%): _____ Areas affected: _____

Prior treatments & reason for discontinuation: _____

_____

Prescription Information

Medication	Directions	Quantity	Refills
☐Dupixent® 300mg (dupilumab)	Initial: ☐Inject 600mg (2 syringes) SQ on day 1.	2 pens/syringes	Zero
	Maintenance: ☐Beginning day 15, inject 300mg SQ every other week.	☐2 pens/syringes	
	☐Other:_____	☐Other:_____	_____
☐Other Medication Drug: Dose:	Directions:	Quantity:	Refills:

Provider Signature: _____ **Date:** _____

My signature for this prescription also authorizes OptiMed Pharmacy and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process.

Additional Information/Notes for the Pharmacy: