

# Atopic Dermatitis Referral Form

Referral for Medication and Patient Management Program

**Phone: 877 385 0535    Fax: 877 326 2856**



Patient Demographics	Provider Information
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Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F DOB: _____ SS#: _____ Phone: _____ 2 <sup>nd</sup> Phone: _____ Address: _____ City: _____ State: _____ Zip: _____ Primary language, if other than English: _____ <b>**Please fax a copy (front and back) of the patient's insurance card as well as any relevant clinical notes/documents**</b>	Prescriber: _____ _____ Phone: _____ Fax: _____ Address: _____ _____ NPI: _____ Office contact: _____ This is a: <input type="checkbox"/> New Rx <input type="checkbox"/> Refill Training by: <input type="checkbox"/> Prescriber's office <input type="checkbox"/> Pharmacy to facilitate <input type="checkbox"/> Not needed Deliver first fill to: <input type="checkbox"/> Prescriber's office <input type="checkbox"/> Patient <input type="checkbox"/> Other: _____
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### Clinical Information

<b>Diagnosis:</b> <input type="checkbox"/> Atopic dermatitis (L20._____) <input type="checkbox"/> Atopic dermatitis, unspecified (L20.9) <input type="checkbox"/> Other: _____	Patient weight: _____ Height: _____ Allergies: _____ BSA affected (%): _____ Areas affected: _____ Prior treatments & reason for discontinuation: _____ _____
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### Prescription Information

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

**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. **Confidentiality statement:** This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error please notify the sender noted above and destroy all transmitted material.

#### Additional Information/Notes for the Pharmacy: