Cosentino's
SPECIALTY CARE

ATOPIC DERMATITIS SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

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: ______

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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 ______

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Topicals	______
❑ Methotrexate	______
❑ Oral Meds	______
❑ Biologics	______
❑ UVA ❑ UVB	______
❑ Others	______

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)

Patient Name: ______ Patient's Date of Birth: ______

Medication	Dosage & Strength	Direction	QTY	Refills
❑ DUPIXENT®	**For ages 6 years and older** ❑ 300mg/2ml Prefilled Syringe ❑ 200mg/1.14ml Prefilled Syringe ❑ 300mg/2ml Prefilled Pen *(only for 12 years and older)* ❑ 200mg/1.14ml Prefilled Pen	❑ **Induction Dose:** ❑ **≥60 kg:** Inject 600mg SC (two 300mg injections) ❑ **30 to <60 kg:** Inject 400mg SC (two 200mg injections) ❑ **15 to <30 kg:** Inject 600mg SC (two 300mg injections)	2	0
		❑ **Maintenance Dose:** ❑ **≥60 kg:** Inject 300mg SC every other week ❑ **30 to <60 kg:** Inject 200mg SC every other week ❑ **15 to <30 kg:** Inject 300mg SC every 4 weeks		
	For Adults ❑ 300mg/2ml Prefilled Syringe ❑ 300mg/2ml Prefilled Pen	❑ **Induction Dose:** ❑ Inject 600mg SC on day one	2	0
		❑ **Maintenance Dose:** ❑ Inject 300mg SC on every other week		
❑ EUCRISA®	❑ 2% Ointment	❑ Apply a thin layer twice daily on affected areas	60g	
			100g	
❑ ______	______	______		

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: ______
Substitution Permitted

Signature: ______ Date: ______
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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