RED CROSS PHARMACY
Our Family Caring For Yours

ATOPIC DERMATITIS SPECIALTY CARE PROGRAM

Phone: **888-216-1949** • Fax: **888-977-1391**

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

❑ 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: ❑ Automatically Draft Appeal for Review ❑ Send Preferred Formulary Alternatives

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ 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®	❑ 300mg/2ml Prefilled Syringe	❑ **Induction Dose:** Inject 600mg SC on day one	2	0
		❑ **Maintenance:** Inject 300mg SC every 2 weeks	2	
❑ EUCRISA™	❑ 2% Ointment	❑ Apply a thin layer twice daily on affected areas	1	
❑ _____	_____	_____		

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.