



**Pediatric Atopic Dermatitis Enrollment Form A-H**

Physician Offices Call: **855-460-7928**  
 Fax: **888-777-5645**

<b>Prescriber:</b>		<b>NPI:</b>
<b>Supervising Physician:</b>		<b>NPI:</b>
Address:		<b>Tax ID:</b>
Phone:	Fax:	
Contact:		

**PATIENT INFORMATION**

Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: / /	SS#: - -
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: Ht.:

**PRESCRIPTION**

Has the patient received a loading dose/starter kit?  Yes Start Date: / /  No SHIP TO:  Patient's Home  Doctor's Office  Other: \_\_\_\_\_

Drug	Directions & Quantity	Refills
<b>Adbry®</b> <input type="checkbox"/> 150 mg Pre-filled Syringe*	<input type="checkbox"/> <b>INITIAL:</b> Inject 300 mg (two 150 mg injections) SQ at day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 150 mg SQ every other week starting at day 15 (Quantity: 2)	
<b>Cibinqo®</b> <input type="checkbox"/> 100 mg Tablet* <input type="checkbox"/> 200 mg Tablet*	<input type="checkbox"/> Take 100 mg PO once daily (Quantity: 30) <input type="checkbox"/> Take 200 mg PO once daily (Quantity: 30) ***Intended for patients who have not achieved adequate response with 100 mg daily dose***	
<b>Dupixent®</b> <input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen*  <input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg Pen*	<input type="checkbox"/> Inject 300 mg SQ every 4 weeks (Quantity: 2) ***Intended for patients age 6 months to 5 years old weight 15 kg/33 lbs to <30 kg/66 lbs***	
	<input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ at day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every 4 weeks starting at day 29 (Quantity: 2) ***Intended for patients age 6 years to 17 years old weight 15 kg/33 lbs to <30 kg/66 lbs***	
	<input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ at day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every other week starting at day 15 (Quantity: 2) ***Intended for weight ≥ 60 kg/132 lbs***	
	<input type="checkbox"/> Inject 200 mg SQ every 4 weeks (Quantity: 2) ***Intended for patients age 6 months to 5 years old weight 5 kg/11 lbs to <15 kg/33 lbs***	
<b>Ebglyss®</b> <input type="checkbox"/> 250 mg Pre-filled Syringe <input type="checkbox"/> 250 mg Pen	<input type="checkbox"/> <b>INITIAL:</b> Inject 500 mg (two 250 mg injections) SQ at week 0 & week 2 (Quantity: 4) <input type="checkbox"/> <b>INDUCTION:</b> Inject 250 mg SQ every 2 weeks starting at week 4 (weeks 4-14) (Quantity: 2 plus 2 refills) <input type="checkbox"/> <b>FINAL INDUCTION:</b> Inject 250 mg SQ (week 16) (Quantity: 1) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 250 mg SQ every 4 weeks (thereafter) (Quantity: 1) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 250 mg SQ every 8 weeks (thereafter) (Quantity: 1) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 250 mg SQ every 2 weeks (thereafter) (Quantity: 2)	***WEIGHT REQUIRED***  ***Intended for patients age 12 years and older weighing ≥ 40 kg/88 lbs***
<b>Eucrisa®</b> <input type="checkbox"/> 2% Ointment 60 gm* <input type="checkbox"/> 2% Ointment 100 gm*	<input type="checkbox"/> Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	

\*Adbry/Dupixent pens/Cibinqo/Ebglyss FDA approved for ages 12 and older

\*Eucrisa FDA approved for ages 3 months and older

**MEDICAL INFORMATION**

\*\*\*PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY\*\*\*

<b>PREVIOUS THERAPIES:</b>	<b>Tried &amp; Failed (Duration):</b>	<b>Not Tolerated:</b>	<b>Contraindication:</b>	
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> ( )	<input type="checkbox"/>	_____	
<input type="checkbox"/> Cyclosporine	<input type="checkbox"/> ( )	<input type="checkbox"/>	_____	
<input type="checkbox"/> Tacrolimus	<input type="checkbox"/> ( )	<input type="checkbox"/>	_____	
<input type="checkbox"/> Elidel	<input type="checkbox"/> ( )	<input type="checkbox"/>	_____	
<input type="checkbox"/> Protopic	<input type="checkbox"/> ( )	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/> ( )	<input type="checkbox"/>	_____	
<b>PHOTOTHERAPY</b>	<b>Tried &amp; Failed (Duration):</b>	<b>Not Tolerated:</b>	<b>Contraindication:</b>	<input type="checkbox"/> Face <input type="checkbox"/> Feet <input type="checkbox"/> Groin <input type="checkbox"/> Hands <input type="checkbox"/> Nails <input type="checkbox"/> Scalp <input type="checkbox"/> Other: _____ <b>Scoring tool used</b> <input type="checkbox"/> BSA <input type="checkbox"/> EASI <input type="checkbox"/> ISGA <input type="checkbox"/> POEM <input type="checkbox"/> SCORAD % or Score: _____ <b>Allergies:</b> _____
<input type="checkbox"/> UVA/UVB	<input type="checkbox"/> ( )	<input type="checkbox"/>	_____	
<input type="checkbox"/> Patient cannot afford	<input type="checkbox"/> Photosensitivity	<input type="checkbox"/> Risk of Skin Cancer	<input type="checkbox"/> Distance from Office	
<input type="checkbox"/> L20.9 Atopic Dermatitis	<input type="checkbox"/> (Mild to Moderate)	<input type="checkbox"/> (Moderate to Severe)		
<input type="checkbox"/> Other: _____	<b>Date of Diagnosis:</b> / /			
Active TB is ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: / /	Hep B ruled out/treated: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: / /	

Additional Clinical Information:

**INJECTION TRAINING**

Patient has received pen and injection training  Physician's office to provide injection training  Senderra to coordinate injection training

**PRESCRIBER SIGNATURE**

To Prescriber: By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

**Prescriber:** \_\_\_\_\_ **Date:** / /

**CONFIDENTIALITY NOTICE**

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