



Atopic Dermatitis Enrollment Form
Physician Offices Call: 855-460-7928
Fax: 888-777-5645

| | | |
|-------------------------------|------|----------------|
| Prescriber: | | NPI: |
| Supervising Physician: | | NPI: |
| Address: | | Tax ID: |
| 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 |
|---|---|---------|
| Adbry™ <input type="checkbox"/> 150 mg Pre-filled Syringe | <input type="checkbox"/> INITIAL: Inject 600 mg SQ on day 1 (Quantity: 4) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every other week starting at day 15 (Quantity: 4) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: 2) <small>***Intended for patients who weigh below 100 kg who achieve clear/almost clear skin after 16 weeks of treatment***</small> | |
| Cibinqo™ <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) <small>***Intended for patients who have not achieved adequate response with 100 mg daily dose***</small> | |
| Dupixent® <input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen | <input type="checkbox"/> INITIAL: Inject 600 mg SQ on day 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every other week starting at day 15 (Quantity: 2) | |
| Eucrisa® <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) | |
| Opzelura™ <input type="checkbox"/> 1.5 % Cream 60 gm | <input type="checkbox"/> Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube) | |
| Rinvoq® <input type="checkbox"/> 15 mg Tablet <input type="checkbox"/> 30 mg Tablet | <input type="checkbox"/> Take 15 mg PO once daily (Quantity: 30) <small>***Intended for patients age 65 and older***</small> <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 30) <small>***Intended for patients under age 65 who have not achieved adequate response with 15 mg daily dose***</small> | |

MEDICAL INFORMATION

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

| | | | | |
|---|--|--|--|---|
| PREVIOUS THERAPIES: | Tried & Failed (Duration): | Not Tolerated: | Contraindication: | <p>Affected Areas</p> <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: Scoring tool used <input type="checkbox"/> BSA <input type="checkbox"/> EASI <input type="checkbox"/> ISGA <input type="checkbox"/> POEM <input type="checkbox"/> SCORAD % or Score: _____ Allergies: _____ |
| <input type="checkbox"/> Methotrexate <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Elidel <input type="checkbox"/> Protopic <input type="checkbox"/> _____ <input type="checkbox"/> _____ | <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ _____ _____ _____ _____ _____ | |
| PHOTOTHERAPY | Tried & Failed (Duration): | Not Tolerated: | Contraindication: | |
| <input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford | <input type="checkbox"/> (_____) | <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: _____ Date of Diagnosis: ____/____/____ | | | | |

Active TB is ruled out: Yes No Date: ____/____/____ Hep B ruled out/treated: Yes 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

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.