PHARMACA
SPECIALTY PHARMACY

ATOPIC DERMATITIS ENROLLMENT FORM

Fax: **888-882-3341**
Call 24/7: **855-465-8892**

1 PATIENT INFORMATION:

Name: ______________________
Address: ______________________
City: ____________ State: _____ Zip: _______
Phone: ____________ Alt Phone: ____________
Email: ______________________
DOB: __________ ☐ M ☐ F Last 4 of SSN: ________

2 PRESCRIBER INFORMATION:

Name: ______________________
Address: ______________________
City: ____________ State: _____ Zip: _______
Phone: ____________ Fax: ____________
NPI: ____________ DEA: ____________
Office Contact: ____________ Phone: ____________

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: ________ Drug Allergies: ☐ NKDA ☐ ______________________

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: ______________________

5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: ____________

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: ____________

PRESCRIPTION INFORMATION:

Medication	Dose/Strength	Directions	Qty	Refills
☐ **Dupixent®**	☐ 300mg/2ml Prefilled Syringe	☐ **Induction:** 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	
☐	☐	☐		

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

PHYSICIAN SIGNATURE REQUIRED

x ______________________ Date
Substitution Permitted

x ______________________ Date
Dispense as Written

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