

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 and Form	Directions	Quantity	Refills
<input type="checkbox"/> Dupixent Cannot break pack of 2 pens/syringes	<input type="checkbox"/> 300 mg/2 mL Prefilled Pen	Induction: <input type="checkbox"/> Inject 600mg SC on day one <input type="checkbox"/> Inject 400mg SC on day one	<input type="checkbox"/> 4 mL <input type="checkbox"/> 2.28 mL	0
	<input type="checkbox"/> 300 mg/2 mL Prefilled Syringe	Maintenance: <input type="checkbox"/> Inject 300 mg SC every 2 weeks <input type="checkbox"/> Inject 300 mg SC every 4 weeks <input type="checkbox"/> Inject 200 mg SC every 2 weeks	<input type="checkbox"/> 4 mL <input type="checkbox"/> 2.28 mL	
	<input type="checkbox"/> 200 mg/1.14 mL Prefilled Syringe			
<input type="checkbox"/> Eucrisa	<input type="checkbox"/> 2% Ointment	<input type="checkbox"/> Apply a thin layer twice daily on affected areas: _____	<input type="checkbox"/> 60 g	
<input type="checkbox"/>				

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 _____ Dispense as Written _____ Date _____
 Substitution Permitted