Atopic Dermatitis
Enrollment Form

Phone: 844-309- 7171
Fax: 844-309- 7173

1. PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies ☐ NKDA	
Date of Birth	SSN#	Weight ________☐kg ☐ lb Date	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address(optional)	

2. INSURANCE INFORMATION

Primary Insurance Rx Ins: BIN # __________ PCN # __________		Policyholder
Group #	Policy #	Phone #

3. DIAGNOSIS & CLINICAL INFORMATION

ICD 10	Description	Therapy ☐ New ☐ Reauthorization ☐ Restart
☐ L20.9	Atopic Dermatitis	Height Weight
		Allergies
		Concomitant Medications
Additional Comments		
Has patient received injection training? ☐ Yes ☐ No ☐ N/A		

4. PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
☐ Dupixent®	☐ Carton of two 300mg/2mL solution pre-filled syringes with needle shield	☐ **Initial Dose:** Inject 600mg SC (two 300mg injections in different injection sites)		
		☐ **Maintenance Dose:** Inject 300mg (one injection) SC every other week		
☐ Other				

5. DELIVERY INSTRUCTIONS

☐ Physician's Office	☐ Other	Date Medication Needed
☐ Patient's Home	Address	
	City/State/Zip	

6. PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	
License #	DEA #	

Physician's Signature ____ **Date** ______________
(required to process prescription – stamped signatures are not permissible)

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173.
Faxed prescription forms will only be accepted from prescribing practitioners.