Atopic Dermatitis REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 PHONE: +1(844) 650-5802

IV Solutions RX

1 PATIENTS INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE

Address: _____ **City/State/Zip:** _____

Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____

Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10) and Patient Clinical Information:

☐ L20.9 Atopic Dermatitis, Unspecified ☐ Other Code: _____ Description: _____

Drug Allergies:_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

Labs: Please ensure labs are dated within 1 year of the patients referral request: ☐ **CMP** ☐ **CBCw/ diff** ☐ **Hep-(B)** ☐ **QuantiFERON**

4 PRESCRIPTION INFORMATION

ACCESS: ☐ SUBCUTANEOUS

MEDICATION	STREGNTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
☐ **ADBRY**	☐ **150 mg/mL PFS** ☐ **300 mg/2 mL PEN**	**Adult Loading Dose:** ☐ Inject 600 mg *(4 x 150 mg/mL pre-filled syringes)* SC on Day 1 ☐ Inject 600 mg *(2 x 300 mg/2 mL PEN)* SC on Day 1	**Q.S**	**(x1) Year**
		Adult Loading Dose: ☐ Inject 300 mg SC every other week	**Q.S**	**(x1) Year**
		Adult Maintenance Dose (After Week 16, if patient achieves clear or almost clear skin and weighs < 100 kg): ☐ Inject 300 mg SC every 4 weeks	**Q.S**	**(x1) Year**
		Pediatric Loading Dose (>12 y/o): ☐ Inject 300 mg *(2 x 150 mg/mL pre-filled syringes)* SC Day 1	**Q.S**	**(x1) Year**
		Pediatric Maintenance Dose (>12 y/o): ☐ Inject 150 mg *(1 x 150 mg/mL pre-filled syringe)* SC every other week	**Q.S**	**(x1) Year**
☐ **DUPIXENT**	☐ **150 mg/mL PFS** ☐ **300 mg/2 mL**	**Adult Patients:** ☐ 600 mg *(two 300 mg injections)* subcutaneously on Day 1, then 300 mg subcutaneously every other week thereafter	**Q.S**	**(x1) Year**
		Pediatric Patients (6 months to 5 years of age): ☐ **5 to less than 15 kg:** 200 mg *(one pre-filled syringe)* every 4 weeks ☐ **15 to less than 30 kg:** 300 mg *(one pre-filled syringe)* every 4 weeks	**Q.S**	**(x1) Year**
		Pediatric Patients (6 years to 17 years of age: ☐ **15 to less than 30 kg:** 600 mg *(two 300 mg injections)* subcutaneously on Day 1, then 300 mg subcutaneously every 4 weeks thereafter ☐ **30 to less than 60 kg:** 400 mg *(two 200 mg injections)* subcutaneously on Day 1, then 200 mg subcutaneously every 2 weeks thereafter ☐ **60 kg or more:** 600 mg *(two 300 mg injections)* subcutaneously on Day 1, then 300 mg subcutaneously every 2 weeks thereafter	**Q.S**	**(x1) Year**
☐ **EBGLYSS**	☐ **250 mg/2 mL**	**Induction Dose (≥ 12 y/o who weigh ≥ 40 kg):** ☐ **Week 0 and 2:** Inject 500 mg *(two 250 mg injections)* SC every 2 weeks ☐ **Week 4-14:** Inject 250 mg *(one injection)* SC every 2 weeks	**Q.S**	**(x1) Year**
		Maintenance Dose (Week 16 or later, when adequate clinical response is achieved): ☐ Inject 250 mg SC every 4 weeks	**Q.S**	**(x1) Year**
ACCESS: ☐ ORAL				
☐ **CIBINQO**	☐ 50mg ☐ 100mg ☐ 200 mg	Take 1 tablet by mouth once daily	**Q.S**	**(x1) Year**
☐ **RINVOQ**	☐ 15mg ☐ 30mg	Take 1 tablet once daily	**Q.S**	**(x1) Year**

5 PRESCRIBER SIGNATURE REQUIRED (***STAMP SIGNATURE NOT ALLOWED***)

Prescriber Name: _____ **Title:** ☐**MD** ☐**DO** ☐**ND** ☐**PA** ☐**APRN** **NPI:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Fax:** _____ **Contact Person:** _____

☐ **DISPENSE AS WRITTEN** ☐ **BRAND MEDICALLY NECESSARY** ☐ **DO NOT SUBSTITUTE** ☐ **NO SUBSTITUTION /** ☐ **DAW /** ☐ **MAY NOT SUBSTITUTE** **Prescriber's Signature:** _____ **Date:** _____	☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible** **Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

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THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE *#welcome to our family*