Community Memorial Pharmacy
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Dermatology (D-E) Dupixent™, Ebglyss™, Enbrel®

Prescriber Information

Prescriber Name _____ ☐ MD ☐ DO ☐ NP ☐ PA NPI _____

Office Contact _____ Practice Name / Collaborating MD _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name _____ Last 4 Digits of SS# _____ DOB / /

Sex ☐ M ☐ F Weight _____ Height _____ Diabetic? ☐ Y ☐ N

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell _____ HIPAA Contact _____

Emergency # _____

Interpreter Needed? ☐ Y ☐ N | Allergies ☐ Y ☐ N If Yes, list allergies _____

Insurance Information

Primary Insurance _____ Policy ID _____ Group# _____

BIN _____ PCN _____

Policyholder Name _____ Policyholder DOB / /

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

ICD-10/Diagnosis Code ☐ Alopecia areata (L63) ☐ Psoriasis Vulgaris (L40.0) ☐ Other Psoriasis (L40.8)
☐ Psoriasis unspecified (L40.9) ☐ Psoriatic Arthritis (L40.5) ☐ Hidradenitis Suppurativa (L73.2)
☐ Chronic Urticaria (L50.8) ☐ Atopic Dermatitis (L20.9) ☐ Basal cell carcinoma (C44.___)
☐ Other _____

TB/PDD Test Given ☐ Y ☐ N Date of Neg. Test / /

HBV Positive? ☐ Y ☐ N If Yes, is patient currently treated? ☐ Y ☐ N

Prior Treatment? ☐ Y ☐ N (Provide Information Below) BSA Affected (%) _____

Affected Areas ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ Other _____

Prior Therapy _____

Reason for Discontinuation of Therapy _____ Approx. Start Date / /
Approx. End Date / /

Comorbidities _____

Concomitant Medications _____

Community Memorial HEALTHCARE

Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **DUPIXENT®** *Pediatrics (age 6 months to 5 years) ☐ PFS ☐ Pen *Dupixent pens only for use in children aged 2 and older	☐ 1 carton (2x200 mg/1.14 ml) ☐ 1 carton (2x300 mg/2 ml)	☐ Weight 5-14 kg: Inject 200 mg SQ every 4 weeks ☐ Weight 15-29 kg: Inject 300 mg SQ every 4 weeks	
☐ **DUPIXENT®** *Pediatrics (age 6 & older) ☐ PFS ☐ Pen	☐ 1 carton (2x200 mg/1.14 ml) ☐ 1 carton (2x300 mg/2 ml)	Starter Dose: ☐ Weight 15-29 kg: Inject 600 mg at week 0. Begin maintenance dose at week 4 ☐ Weight 30-59 kg: Inject 400 mg SQ at week 0. Begin maintenance dose at week 2 ☐ Weight ≥ 60 kg: Inject 600 mg SQ at week 0. Begin maintenance dose at week 2	No Refills
	☐ 1 carton (2x200 mg/1.14 ml) ☐ 1 carton (2x300 mg/2 ml)	Maintenance Dose: ☐ Weight 15-29 kg: Inject 300 mg SQ every 4 weeks ☐ Weight 30-59 kg: Inject 200 mg SQ every 2 weeks ☐ Weight ≥ 60 kg: Inject 300 mg SQ every 2 weeks	
☐ **DUPIXENT®** *Adults ☐ PFS ☐ Pen	☐ 1 carton (2x300 mg/2 ml)	☐ Starter Dose: Inject 600 mg SQ at week 0. Begin maintenance dose at week 2	No Refills
	☐ 1 carton (2x300 mg/2 ml)	☐ Maintenance Dose: Inject 300 mg SQ every 2 weeks	
☐ **EBGLYSS™**	☐ QS for appropriate month of starter dose schedule	Starter Dose: ☐ Inject 500 mg (two 250 mg injections) SQ at week 0 and 2, then 250 mg SQ every 2 weeks until week 16 or later (when adequate clinical response is achieved)	4 Refills
	☐ 1 carton (1x250 mg/2 ml) PEN	Maintenance Dose: ☐ Inject 250 mg SQ every 4 weeks	

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **ENBREL®** *Adults ☐ Mini™ ☐ PFS ☐ SureClick® ☐ Vial	☐ 2 cartons (8x50 mg/mL)	☐ Starter Dose: Inject 50 mg SQ twice a week (72-96 hours apart) x 3 months	2 Refills
	☐ 1 carton (4x50 mg/mL)	☐ Maintenance Dose: Inject 50 mg SQ every week	
☐ **ENBREL®** *Pediatrics *25 mg dose only available in vial & PFS ☐ Mini™ ☐ PFS ☐ SureClick® ☐ Vial	☐ 1 carton (4x25 mg/mL) ☐ 1 carton (4x50 mg/mL)	☐ Weight <63 kg: Inject _____mg (0.8 mg/kg) SQ once a week ☐ Weight ≥ 63 kg: Inject 50 mg SQ once a week	

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____ *Substitution Permitted*
Date _____

Prescriber Signature _____ *Dispense as Written*
Date _____

If brand is required, please write "DAW" in the box to the right. ☐