MEDROCS PHARMACY

ATOPIC DERMATITIS ENROLLMENT FORM

FAX : (469) 519-9100
CALL : (469) 625-1000
WEBSITE : www.medrocs.com
ADDRESS: 8901 VIRGINIA PARKWAY STE 200
MCKINNEY, TX 75071

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
☐ **Dupixent** Cannot break pack of 2 pens/syringes	☐ 300 mg/2 mL Prefilled Pen ☐ 300 mg/2 mL Prefilled Syringe ☐ 200 mg/1.14 mL Prefilled Syringe	**Induction:** ☐ Inject 600mg SC on day one ☐ Inject 400mg SC on day one **Maintenance:** ☐ Inject 300 mg SC every 2 weeks ☐ Inject 300 mg SC every 4 weeks ☐ Inject 200 mg SC every 2 weeks	☐ 4 mL ☐ 2.28 mL ☐ 4 mL ☐ 2.28 mL	0
☐ **Eucrisa**	☐ 2% Ointment	☐ Apply a thin layer twice daily on affected areas: _____	☐ 60 g	
☐				

I AUTHORIZE MEDROCS AND ITS AFFILIATES TO ACT ON MY BEHALF TO OBTAIN PRIOR AUTHORIZATION AND/OR OTHER ASSISTANCE IF APPLICABLE, I ACKNOWLEDGE THE PRIOR AUTHORIZATION/ PAYMENT IS NOT GUARANTEED.

x PHYSICIAN SIGNATURE REQUIRED _____ x _____

Substitution Permitted Date Dispense as Written Date