Publix Specialty Pharmacy #3213

ATOPIC DERMATITIS

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________________ Patient's Last Name: ______________________________

Date of Birth: _____/_____/________ Male Female Caregiver Name: ______________________________

Address: ______________________________ City: ___________________ State: ___________ Zip: ______________

Primary Phone Number: (_____) ______________________________ Alt. Phone Number: (_____) ______________________________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code(s): ________________ Diagnosis: ☐ Atopic dermatitis (AD) ☐ Other: ______________________________

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in

Treatment status: ☐ New to therapy Is the patient on samples? ☐ No ☐ Yes Weight: ______ ☐ kg ☐ lb

☐ Continuation of therapy, start date: ______/______/________

BSA affected: _______________ % EASI score: ____________ or POEM score: ____________ or SCORAD score: _____________

TB test results (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: _____/______/_________

Allergies: ☐ NKDA ☐ Other: ______________________________

Prior therapy, treatment dates, and reason for discontinuation: ______________________________

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Adbry (tralokinumab)	☐ 150 mg/mL prefilled syringe (PFS)	Initial Dose: ☐ Inject 600 mg SC once	1 dose	0
		Maintenance Dose: ☐ Inject 300 mg SC every other week ☐ Inject 300 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_______
☐ Cibinqo (abrocitinib)	☐ 50 mg tablet ☐ 100 mg tablet ☐ 200 mg tablet	Take 1 tablet PO one time daily	☐ 30 days ☐ 90 days	_______
☐ Dupixent (dupilumab)	☐ 300 mg/2mL pen ☐ 300 mg/2mL PFS ☐ 200 mg/ 1.14 mL pen ☐ 200 mg/ 1.14 mL PFS Pediatric Patient Wt: __________	Initial Dose: ☐ Inject 600 mg SC once ☐ Inject 400 mg SC once	1 dose	0
		Maintenance Dose: ☐ Inject 300 mg SC every other week ☐ Inject 300 mg SC every 4 weeks ☐ Inject 200 mg SC every other week ☐ Inject 200 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_______
☐ Rinvoq (upadacitinib)	☐ 15 mg tablet ☐ 30 mg tablet	Take 1 tab PO one time daily	☐ 30 days ☐ 90 days	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ______/______/__________

Name: ______________________________ DEA# ____________________ NPI # ______________________________

Supervising Physician: ☐ Not Applicable ☐ ______________________________ Supervising Physician NPI # ______________________

Address: ______________________________ City: __________________ State: ___________ Zip: ______________

Office Phone Number: (_____) ________________ Fax Number: (_____) __________________ Office Contact: ______________________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted) ____________________________ ____________________________

☐ Substitution allowed Date ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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