Genefic
SPECIALTY PHARMACY

To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: _____

Email: _____

Direct Phone Line: _____

Cell (optional, but preferred): _____

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Genefic Specialty Pharmacy.

Pediatric Atopic Dermatitis Enrollment Form

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐**Yes Start Date:** ____/____/_____ ☐**No** | **SHIP TO:** ☐**Patient's Home** ☐**Doctor's Office** ☐**Other:**_____

Drug		Directions & Quantity	Refills
Adbry®	☐ 150 mg Pre-filled Syringe*	☐ **INITIAL:** Inject 300 mg (two 150 mg injections) SQ at day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 150 mg SQ every **other** week starting at day 15 (Quantity: 2)	
Cibinqo™	☐ 100 mg Tablet* ☐ 200 mg Tablet*	☐ Take 100 mg PO once daily (Quantity: 30) ☐ Take 200 mg PO once daily (Quantity: 30) ***Intended for patients who have not achieved adequate response with 100 mg daily dose***	
Dupixent®	☐ 300 mg Pre-filled Syringe ☐ 300 mg Pen*	***WEIGHT REQUIRED*** _____ ☐ Inject 300 mg SQ every 4 weeks (Quantity: 2) ***Intended for patients age 6 months to 5 years old weight 15 kg/33 lbs to <30 kg/66 lbs*** ☐ **INITIAL:** Inject 600 mg SQ at day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 300 mg SQ **every 4 weeks** starting at day 29 (Quantity: 2) ***Intended for patients age 6 years to 17 years old weight 15 kg/33 lbs to <30 kg/66 lbs*** ☐ **INITIAL:** Inject 600 mg SQ at day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2) ***Intended for patients age 6 years to 17 years Intended for weight ≥ 60 kg/132 lbs***	
	☐ 200 mg Pre-filled Syringe ☐ 200 mg Pen*	☐ Inject 200 mg SQ every 4 weeks (Quantity: 2) ***Intended for patients age 6 months to 5 years old weight 5 kg/11 lbs to <15 kg/33 lbs*** ☐ **INITIAL:** Inject 400 mg SQ at day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every **other** week starting at day 15 (Quantity: 2) ***Intended for patients age 6 years to 17 years Intended for weight 30 kg/66 lbs to < 60 kg/132	
Eucrisa®	☐ 2% Ointment 60 gm* ☐ 2% Ointment 100 gm*	☐ Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Opzelura™	☐ 1.5 % Cream 60 gm*	☐ Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Rinvoq®	☐ 15 mg Tablet*	***WEIGHT REQUIRED*** _____ ☐ Take 15 mg PO once daily (Quantity: 30) ***Intended for patients age 12 years and older weighing ≥ 40 kg/88 lbs***	
	☐ 30 mg Tablet*	☐ Take 30 mg PO once daily (Quantity: 30) ***Intended for patients age 12 years and older weighing ≥ 40 kg/88 lbs if adequate response was not achieved with 15 mg daily dose***	

**Adbry/Dupixent pens/Cibinqo/Opzelura/Rinvoq FDA approved for ages 12 and over* | **Eucrisa FDA approved for ages 3 months and over*

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

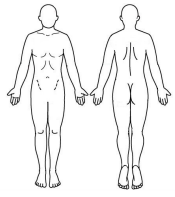
PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Cyclosporine	☐ (_____)	☐	_____
☐ Tacrolimus	☐ (_____)	☐	_____
☐ Elidel	☐ (_____)	☐	_____
☐ Protopic	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ UVA /UVB	☐ (_____)	☐	_____

☐ Patient cannot afford ☐ Photosensitivity ☐ Risk of Skin Cancer ☐ Distance from Office

☐ L20.9 Atopic Dermatitis ☐ (**Mild to Moderate**) ☐ (**Moderate to Severe**)

☐ Other: _____ **Date of Diagnosis**: ____/____/_____



Affected Areas

☐ Face ☐ Feet ☐ Groin ☐ Hands
☐ Nails ☐ Scalp ☐ Other:

Scoring tool used

☐ BSA ☐ EASI ☐ ISGA ☐ POEM
☐ SCORAD % or Score: _____

Allergies:

Active TB is ruled out: ☐Yes ☐No Date: ____/____/_____ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/_____

Additional Clinical Information:

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Genefic to coordinate injection training

PRESCRIBER SIGNATURE

To Prescriber : By signing this form and utilizing our services, you are also authorizing Genefic Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date**: ____/____/_____

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.