LINDEN
RETAIL SPECIALTY PHARMACY

ATOPIC DERMATITIS ENROLLMENT FORM

Phone: 908-583-6665 | Fax: 888-474-0976
Email: lindensprx@gmail.com

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name | Address | City, State, ZIP

Preferred Contact Methods ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone | Alternate Phone | Date of Birth | Gender ◯ Male ◯ Female

Email | Last Four of SSN | Primary Language

2 PRESCRIBER INFORMATION

Prescriber's Name | State License Number

NPI Number | DEA Number | Group or Hospital

Address | City, State, ZIP

Phone | Fax | Contact Person | Contact's Phone

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date | Ship to ☐ Patient ☐ Office ☐ Other

Diagnosis (ICD-10):

☐ L20.9 Atopic Dermatitis, Unspecified ☐ Other Code | Description

Patient Clinical Information

Allergies | Weight | lb/kg | Height | in/cm | TB Test Result | Date

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Dupixent®	Carton of two 300 mg/2 mL solution pre-filled syringes with needle shield	☐ Initial Dose: Inject 600 mg SC (two 300 mg injections in different injection sites) initially, then 300 mg SC every other week. ☐ Maintenance Dose: Inject 300 mg (one injection) SC every other week.	Quantity Refills
☐ Other	☐ Other	☐ Other:	Quantity Refills

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** **Ancillary supplies and kits provided as needed for administration**

6 PHYSICIAN SIGNTURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (DATE) DISPENSE AS WRITTEN (DATE)