

Please fax all pages of completed form to your team at 866.531.1025.

To reach your team, call toll-free 866.839.2162.

You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](http://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form

**Adbry® (tralokinumab-ldrm)**

*accredo*®

Four simple steps to submit your referral.

## 1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient    Current patient

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Preferred patient first name \_\_\_\_\_ Preferred patient last name \_\_\_\_\_

Sex at birth:    Male    Female    Gender identity \_\_\_\_\_    Pronouns \_\_\_\_\_    Last 4 digits of SSN \_\_\_\_\_

Date of birth \_\_\_\_\_ Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

OK to leave message with alternate caregiver/contact

Patient's primary language:    English    Other    If other, please specify \_\_\_\_\_

## 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_

Prescriber's title \_\_\_\_\_ If NP or PA, under direction of Dr. \_\_\_\_\_

Office phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Office contact and title \_\_\_\_\_ Office contact email \_\_\_\_\_

Office street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Deliver product to:    Prescriber's office    Patient's home

## 3 Clinical Information

ICD-10 code (REQUIRED):    Atopic Dermatitis, unspecified (L20.9)    Other \_\_\_\_\_

NKDA    Known drug allergies \_\_\_\_\_

Prior anaphylactic reaction:    Yes (Reason/date \_\_\_\_\_)    No

Concurrent meds \_\_\_\_\_ Estimated % BSA involvement \_\_\_\_\_

Concomitant therapies:    Short-acting beta agonist    Long-acting beta agonist    Antihistamines    Decongestants    Immunotherapy

Inhaled corticosteroid    Leukotriene modifiers    Oral steroids    Nasal steroids    Other \_\_\_\_\_

Lab results:    History of positive skin OR RAST test to a perennial aeroallergen

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

### 3 Prescribing Information (continued)

Pre-treatment steroid dose \_\_\_\_\_ mg Pre-treatment serum IgE level \_\_\_\_\_ IU per mL Test date \_\_\_\_\_

Pre-treatment serum eosinophils \_\_\_\_\_ cells/mcL and/or sputum eosinophils \_\_\_\_\_ Date \_\_\_\_\_

Patient wt \_\_\_\_\_ kg Date wt obtained \_\_\_\_\_

MD Specialty (required): Allergist Pulmonologist ENT Primary care Pediatrician Dermatologist Other \_\_\_\_\_

Prescription type: Naïve/new start Restart Continued therapy

Prior therapies: Please fax detailed medication history with dates of use as available. Required by some plan authorization criteria.

Topical steroid(s) Oral antihistamines Topical PDE-4 inhibitor Oral steroids Oral immunosuppressants

Topical calcineurin inhibitor Sinus surgery

### 4 Prescribing Information

Medication	Strength / Formulation and Directions	Quantity/Refills
Adbry® (tralokinumab) 150mg/mL prefilled syringe 4-pack Adbry® (tralokinumab) 150mg/mL prefilled syringe 2-pack <b>(ADULT)</b>	<b>Starter Dose:</b> Inject four syringes (total of 600mg) under the skin on Day 1 then two syringes (300mg) every 2 weeks starting on day 15 and thereafter. <b>Maintenance Dose:</b> Inject 300mg under the skin every 2 weeks.	1-month supply 3-month supply Other: _____ Refills _____
Adbry® (tralokinumab) 150mg/mL prefilled syringe 2-pack <b>(PEDIATRIC ages 12–17)</b>	<b>Starter Dose:</b> Inject two syringes (total of 300mg) under the skin on Day 1 then one syringe (150mg) every 2 weeks starting on day 15 and thereafter. <b>Maintenance Dose:</b> Inject 150mg under the skin every 2 weeks.	1-month supply 3-month supply Other: _____ Refills _____

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

**Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)**

**SIGN  
HERE**

Date

Dispense as written

Date

Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.