# Please fax both pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

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# **Prescription & Enrollment Form** Cibinqo<sup>™</sup> (abrocitinib)

677 Ala Moana Blvd., Suite 4 Honolulu, HI 96813-5412

# Four simple steps to submit your referral.

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
Sex at birth: Male Female Prefer	red pronouns	Last 4 digits of SSN	Date of birth
Street address			Apt #
City	Stat	e	Zip
Home phone	Cell phone	Email address	
Parent/guardian (if applicable)			
Home phone			
Alternate caregiver/contact			
Home phone			
OK to leave message with alternate o	aregiver/contact		
Patient's primary language: English	Other If other, please sp	pecify	

#### **Prescriber Information** 2

All fields must be completed to expedite prescription fulfillment.

Date	Time Date medication needed		
Office/clinic/institution 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):

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
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 authrization criteria.
Topical steroid(s) Oral antihistamines Topical PDE-4 inhibitor Oral steroids Oral immunosuppressants
Topical calcineurin inhibitor Sinus surgery

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Patient's first name	Last name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

# **4** Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Cibinqo™ (abrocitinib)	50mg tablets 100mg tablets 200mg tablets	Take one tablet by mouth once daily	Quantity Refills

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

SIGN HERE				
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. Noncompliance with state-specific requirements could result in outreach to the prescriber.



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