Please fax both 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 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 _____

Male Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail 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 _____

Prescriber's first name _____ Last name _____

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

Office/Clinic/Institution name _____

Office address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Infusion clinic affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Infusion clinic contact name _____ E-mail address _____

Deliver product to: 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 authrization 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	**Starter Dose:** 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. **Maintenance Dose:** Inject 300mg 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.

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