

PATHFINDER-AD: Patient Eligibility and Readiness for Advanced Therapies Targeting IL-4/IL-13 and IL-13 in Moderate to Severe Atopic Dermatitis

GENERAL INFORMATION

PATIENT INFORMATION

Name:

Age:

MEDICAL HISTORY

Diagnosis:

Date of first visit:

Comorbidities: Please list all known conditions

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Concurrent medication(s): Please list all medications the patient has been prescribed to manage comorbidities

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.....
.....

Allergies: Please list all known allergies

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.....

TREATMENT HISTORY

Previous treatment for AD:

ADVERSE REACTIONS *(Please check all that apply and relevant details)*

Skin thinning (atrophy): ☐ Yes ☐ No

Stretch marks: ☐ Yes ☐ No

Burning sensation: ☐ Yes ☐ No

Redness: ☐ Yes ☐ No

Skin sensitivity: ☐ Yes ☐ No

Spider veins: ☐ Yes ☐ No

Hypopigmentation: ☐ Yes ☐ No

When to Consider Therapies Targeting IL-4/IL-13 and IL-13

ELIGIBILITY CRITERIA FOR SYSTEMIC TREATMENT

A. CLINICAL SEVERITY

At least 1 of the following criteria is fulfilled: ☐ Yes ☐ No

- Investigator Global Assessment (IGA) = 3 or 4
- Body surface area: $\geq 10\%$
- Patient-Oriented Eczema Measure (POEM) = moderate to severe
- SCORing Atopic Dermatitis (SCORAD) = moderate to severe
- Treatment-refractory AD in sensitive areas (eg, head/neck, hands, feet, genitalia)
- Persistent or multiple AD flares over a 3-month time period (episodes requiring an escalation of treatment or seeking additional medical advice) despite appropriate maintenance topical therapy

B. SUBJECTIVE BURDEN

At least 1 of the following criteria is fulfilled: ☐ Yes ☐ No

- DLQI-validated questionnaire on the impact of AD on quality of life = 3 (0 = not at all; 3 = very much)
- Atopic Dermatitis Control Tool (ADCT) score ≥ 7
- Itch score ≥ 6

C. LACK OF TREATMENT RESPONSE

All other therapeutic approaches are insufficient because at least 1 of the following criteria is fulfilled: ☐ Yes ☐ No

- Patient indicates that there is an inadequate response to appropriate prescription topical therapy for moderate to severe AD
- No provider expectation of success with prescription topical therapy alone
- Prescription topical therapy, as needed for control, is not safe or feasible
- Patient agrees with IL-13 treatment initiation

SUMMARY

Systemic treatment is indicated because 1 or more criteria from each A, B, and C section are fulfilled

☐ Yes ☐ No

DOSING SCHEDULE

DOSE INFORMATION

Date of first dose:

Prescribing doctor: Prescribing doctor phone:

Dosing schedule: ☐ QW ☐ Q2W

Date of next full dose: ☐ QW dose date: ☐ Q2W dose date:

ADVERSE REACTIONS *(Please check all that apply and relevant details)*

Injection-site reaction: ☐ Yes ☐ No

Upper respiratory tract infection: ☐ Yes ☐ No

Headaches: ☐ Yes ☐ No

Ocular infections: ☐ Yes ☐ No

Symptoms experienced:

Maximum grade experienced: Number of days hospitalized:

Management notes:

FOLLOW-UP CARE PLAN

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(Please note need for ongoing treatment for other comorbidities)

SCHEDULE OF CLINICAL VISITS

(Please note coordinating provider: what/where/when/frequency)

RECOMMENDED RELATED TESTS

(Please note coordinating provider: what/where/when/frequency)

OTHER *(Please note possible late and ongoing adverse events that someone with this type of treatment may experience)*