

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION
<input type="checkbox"/> J45.40 Moderate persistent asthma, uncomplicated <input type="checkbox"/> J45.50 Severe persistent asthma, uncomplicated <input type="checkbox"/> J82.83 Eosinophilic asthma <input type="checkbox"/> J45.51 Severe persistent asthma with (acute) exacerbation <input type="checkbox"/> J33.9 Nasal polyp, unspecified <input type="checkbox"/> J33.0 Polyp of nasal cavity <input type="checkbox"/> L50.1 Idiopathic urticaria <input type="checkbox"/> Other ICD-10 Code (Please Specify Diagnosis): _____ <input type="checkbox"/> 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: _____ Prior therapies: <input type="checkbox"/> Topical steroid(s) <input type="checkbox"/> Oral antihistamines <input type="checkbox"/> Topical PDE-4 inhibitor <input type="checkbox"/> Oral steroids <input type="checkbox"/> Oral immunosuppressants <input type="checkbox"/> Topical calcineurin inhibitor <input type="checkbox"/> Sinus surgery

DRUG ORDERS
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Qty/Refills
<input type="checkbox"/> Dupixent® (dupilumab) 200mg/1.14mL pre-filled pen (2-pack) <input type="checkbox"/> Dupixent® (dupilumab) 200mg/1.14mL pre-filled syringe (2-pack) <input type="checkbox"/> Dupixent® (dupilumab) 300mg/2mL pre-filled pen (2-pack) <input type="checkbox"/> Dupixent® (dupilumab) 300mg/2mL pre-filled syringe (2-pack)	Starter Dose: (Only Complete This Section If Starter Dose Is Needed) <input type="checkbox"/> Inject 400mg under the skin on Day 1 then 200mg every 2 weeks starting on day 15 and thereafter. <input type="checkbox"/> Inject 600mg under the skin on Day 1 then 300mg every 2 weeks starting on day 15 and thereafter. <input type="checkbox"/> Inject 600mg under the skin on Day 1 then 300mg every 4 weeks thereafter starting on day 29.	Starter dose: Qty 1 (2-pack) No refills
	Maintenance Dose: <input type="checkbox"/> Inject 200mg under the skin every 2 weeks. <input type="checkbox"/> Inject 300mg under the skin every 2 weeks. <input type="checkbox"/> Inject 300mg under the skin every 4 weeks.	Maintenance dose: Days supply: _____ Refills: _____
	No starter dose indicated or required: <input type="checkbox"/> Inject 200mg under the skin every 2 weeks. <input type="checkbox"/> Inject 200mg under the skin every 4 weeks. <input type="checkbox"/> Inject 300mg under the skin once weekly. <input type="checkbox"/> Inject 300mg under the skin every 2 weeks. <input type="checkbox"/> Inject 300mg under the skin every 4 weeks.	For orders without a starter dose: Days supply: _____ Refills: _____

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Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> _____	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed <input type="checkbox"/> _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV <input type="checkbox"/> 25mg PO <input type="checkbox"/> 50mg IV <input type="checkbox"/> 50mg PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> _____
<input type="checkbox"/> _____	_____	_____

ANAPHYLACTIC REACTION (AR):

- EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary
- EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary
- Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary
- Hydrocortisone 100mg - Give 100 mg IVP -or- IM if no IV access
- Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr
- Other: _____

SIGNATURE

Prescriber Signature: _____ Date: _____
 (Substitutions Allowed) (Brand Medically Necessary)

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