DUPIXENT REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:		Sex: ❑M ❑F	Weight:		❑lbs. ❑kg.
SSN:	Phone:	Allergies:					
Address:			City:		State:	Zip:	
Emergency Contact:		Phone:		❑**Please attach demographic information**			

PRESCRIBER INFORMATION

Prescriber:		NPI:		DEA:		State Lic:	
Supervising Physician:			Practice Name:				
Address:			City:		State:	Zip:	
Phone:		Fax:	Key Office Contact:			Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) _____

- Has patient been treated *previously* for this condition? ❑Yes ❑No Please list medication(s) and treatment duration:
_____

- Is patient *currently* on therapy? ❑Yes ❑No Please list medication(s) and treatment duration:
_____

- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If *yes*, how long should patient wait before starting the new medication?
_____

- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
_____

INSURANCE INFORMATION

❑**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑**Please check if enrolling in copay card**   Copay ID:

PRESCRIPTION INFORMATION

❑**Dupixent (Dupilumab) 200 mg/1.14 mL Prefilled Syringe** ❑New start ❑Existing therapy

	QTY:	Refills:
❑ Starter Dose: Inj. 400 mg (2 syringes) SQ on Day 1, then 200 mg (1 syringe) SQ every other Week starting on Day 15	QTY: _____	Refills:__0__
❑Maintenance Dose: Inj. 200 mg (1 syringe) SQ every 2 Weeks	QTY: _____	Refills:_____

❑**Dupixent (Dupilumab) 300 mg/2 mL Prefilled Syringe** ❑New start ❑Existing therapy

	QTY:	Refills:
❑ Starter Dose: Inj. 600 mg (2 syringes) SQ on Day 1, then 300 mg (1 syringe) SQ every 2 Weeks starting on Day 15	QTY:__2__	Refills:__0__
❑Maintenance Dose: Inj. 300 mg (1 syringe) SQ every 2 Weeks	QTY:__2__	Refills:_____

Prescriber's Signature: _____   ❑ DAW (Dispense as Written)   **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

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