Star Discount Pharmacy specialty care

Eosinophilic Esophagitis

Call: (877) 883-1392 Fax: (256) 429-2221

Patient Information: Name: ______________________________ DOB: ___________ Gender: ○M ○F Last 4 of SSN: __________
Address: ____________________________ City: _______________ State: ____ Zip: ________ Phone: ____________ Alt. Phone: ____________
Email: ______________________ Ht: _____ Wt: ____ Care Giver: _______________________ Allergies: ○No Known ○See Attached Charts

Prescriber Information: Name: ________________________________ Address: ______________________________City: ________________
State: ______ Zip: __________ NPI: _______________________ Phone: _____________ Fax: _____________ Office Contact: ________________

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: ____________ **ICD-10:** ____ **Other:** _________________ **Date:** _____________

Diagnosis of Eosinophilic Esophagitis ≥12 years old & ≥88lb (40kg):

Diagnosed by: ○ Endoscopy ○ Clinical Presentation
Assessment: ○ Moderate ○ Mod to Severe ○ Severe

Eosinophil Level: ____________________________ Test Date: ____________

Injection Training:
- ○ Pharmacist to Provide Training
- ○ Patient Trained in MD Office
- ○ Manufacturer Nurse Support

Product Delivery:
- ○ Patient's Home
- ○ Physician's Office
- ○ Pharmacy to Coordinate

Prior Failed Treatments	Drug Name & Length of Treatment
○ Diet	
○ PPI	
○ Oral/Topical Corticosteroids	
○ Surgical Intervention or Procedure	
○ Other	

Prescription Information:

Medication	Dosage & Strength	Directions	Qty	Refills
○ Dupixent	○ 300mg/2ml Prefilled Syringe ○ 300mg/2ml Pen	○ Initial and Maintenance Dose: Inject 300mg SQ every week	4	

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: ________________________________ Signature________________________________ Date: ______________

Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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