Star Discount Pharmacy specialty care

Respiratory

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 Mod-Sev Asthma in patients > 12 Years Old:

Diagnosed by: ○ Endoscopy ○ CT Scan
Assessment: ○ Moderate ○ Mod to Severe ○ Severe
Number of severe exacerbations in the last 12 months that required systemic corticosteroids, ER visits, or hospitalization: ____
Blood Eosinophil Level: _____ Test Date: _____
IgE Level (if atopic comorbidities): _____ Test Date: _____
Pulmonary Function Test Results:
Pre-Bronchodilator FEV1: _____ Test Date: _____
FeNO Levels (if applicable) _____ Test Date: _____

Prior Failed Treatments	Drug Name & Length of Treatment
○ Biologics	
○ ICS	
○ ICS + LABA	
○ Intranasal Corticosteroids	
○ LABA	
○ Oral Corticosteroids	
○ Other Controllers	
○ Sinus Surgery	

Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) in patients >18 Years Old:

Diagnosed by: ○ Rhinoscopy ○ Nasal Endoscopy ○ CT Scan
Documentation of Ongoing Symptoms?
○ Nasal Obstruction or Discharge ○ Facial Pain or Pressure
○ Reduction in or Loss of Smell ○ N/A
Results and date of last CT scan or endoscopy including polyp location/catherization, if applicable: _____ Test Date: _____

History of nasal surgeries and procedures? ○Yes ○No
○ Endoscopic Polyp Removal (Polypectomy)
○ Functional Endoscopic Sinus Surgery (FESS)
○ Other: _____
If no, please state reason(s) patient may not be a candidate for surgery:
_____

Prior Failed Treatments	Drug Name & Length of Treatment
○ Oral Corticosteroids	
○ Intranasal Corticosteroids	
○ Surgery	
○ Other	

Inadequately Controlled COPD and an Eosonophilic phenotype in patients > 18 Years Old:

COPD:Eosinophil count_____cells/uL Test Date:_____

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

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

Prescription Information:

Medication	Dosage & Strength	Directions	Qty	Refills
○ Dupixent	○ 200mg/1.14ml Prefilled Syringe ○ 300mg/2ml Prefilled Syringe ○ 300mg/2ml Prefilled Pen ○ 200mg/1.14 mL Prefilled Pen *For patients who require concomitant oral corticosteroids or with comorbid moderate to severe atopic dermatitis for which Dupixent® is indicated, start with an initial dose of 600mg SC followed by 300mg SC given every other week*	**For adults and adolescents 12 years of age and older:** ○ **Induction Dose:** Inject 400mg SC on day one	2	0
		○ **Maintenance:** Inject 200mg SC every other week	2	
		○ **Induction Dose:** Inject 600mg SC on day one	2	0
		○ **Maintenance:** Inject 300mg SC every other week	2	
		○ **For adults with chronic rhinosinusitis with nasal polyposis**: Inject 300mg SC every other week	2	
○Nucala	○100mg/mL Prefilled Autoinjector ○100mg/mL Prefilled Syringe	○ **For adults and adolescents 12 years of age and older:** Inject 100mg SC once every 4 weeks	1	
○_____	○_____	○_____		

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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