

**Patient Information:** Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  M  F  
 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
<input type="radio"/> Biologics	
<input type="radio"/> ICS	
<input type="radio"/> ICS + LABA	
<input type="radio"/> Intranasal Corticosteroids	
<input type="radio"/> LABA	
<input type="radio"/> Oral Corticosteroids	
<input type="radio"/> Other Controllers	
<input type="radio"/> 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
<input type="radio"/> Oral Corticosteroids	
<input type="radio"/> Intranasal Corticosteroids	
<input type="radio"/> Surgery	
<input type="radio"/> Other	

**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

**Prescription Information:**

Medication	Dosage & Strength	Directions	Qty	Refills
<input type="radio"/> Dupixent	<input type="radio"/> 200mg/1.14ml Prefilled Syringe <input type="radio"/> 300mg/2ml Prefilled Syringe <input type="radio"/> 300mg/2ml Prefilled Pen <i>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</i>	<b>For adults and adolescents 12 years of age and older:</b>		
		<input type="radio"/> Induction Dose: Inject 400mg SC on day one	2	0
		<input type="radio"/> Maintenance: Inject 200mg SC every other week	2	
		<input type="radio"/> Induction Dose: Inject 600mg SC on day one	2	0
<input type="radio"/> _____	<input type="radio"/> _____	<input type="radio"/> Maintenance: Inject 300mg SC every other week	2	
		<b>For adults with chronic rhinosinusitis with nasal polyposis:</b>		
<input type="radio"/> _____	<input type="radio"/> _____	<input type="radio"/> Inject 300mg SC every other week	2	
<input type="radio"/> _____	<input type="radio"/> _____	<input type="radio"/> _____		

**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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