

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	For adults and adolescents 12 years of age and older: <input type="radio"/> Induction Dose: Inject 400mg SC on day one <input type="radio"/> Maintenance: Inject 200mg SC every other week	2	0
	<input type="radio"/> 300mg/2ml Prefilled Syringe		2	
	<input type="radio"/> 300mg/2ml Prefilled Pen	<input type="radio"/> Induction Dose: Inject 600mg SC on day one <input type="radio"/> Maintenance: Inject 300mg SC every other week	2	0
	<input type="radio"/> 200mg/1.14 mL 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>		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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