Star Discount Pharmacy specialty care

Pediatric 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 ≥6 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	

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
○ Dupixent	○ 100mg/0.67ml Prefilled Syringe ○ 200mg/1.14ml Prefilled Syringe ○ 300mg/2ml Prefilled Syringe	○ >30kg Inject 200mg SC every other week	2	0
		15kg to <30kg ○ Inject 100mg SC every other week OR ○ Inject 300mg SC every 4 weeks	2	0
			2	0

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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