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.