

Date Shipment Needed: _____ Ship To: Patient Prescriber
 Nursing needed; Training needed ► All the supplies including syringes and needles will be dispensed if needed.

DUPIXENT REFERRAL FORM

PATIENT INFORMATION					
Patient Name:			DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> Please attach demographic information		
PRESCRIBER INFORMATION					
Prescriber:		NPI:	DEA:	State Lic:	
Supervising Physician:			Practice Name:		
Address:		City:	State:	Zip:	
Phone:	Fax:	Key Office Contact:		Phone:	
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT					
Primary Diagnosis: (ICD-10 Code & Description) _____					
▪ Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list medication(s) and treatment duration: _____					
▪ Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list medication(s) and treatment duration: _____					
▪ Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long should patient wait before starting the new medication? _____					
▪ Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____					
INSURANCE INFORMATION					
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)					
COPAY CARD ENROLLMENT					
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____			
PRESCRIPTION INFORMATION					
<input type="checkbox"/> Dupixent (Dupilumab) 200 mg/1.14 mL Prefilled Syringe <input type="checkbox"/> New start <input type="checkbox"/> Existing therapy					
<input type="checkbox"/> Starter Dose: Inj. 400 mg (2 syringes) SQ on Day 1, then 200 mg (1 syringe) SQ every other Week starting on Day 15				QTY: _____	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose: Inj. 200 mg (1 syringe) SQ every 2 Weeks				QTY: _____	Refills: _____
<input type="checkbox"/> Dupixent (Dupilumab) 300 mg/2 mL Prefilled Syringe <input type="checkbox"/> New start <input type="checkbox"/> Existing therapy					
<input type="checkbox"/> Starter Dose: Inj. 600 mg (2 syringes) SQ on Day 1, then 300 mg (1 syringe) SQ every 2 Weeks starting on Day 15				QTY: <u>2</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose: Inj. 300 mg (1 syringe) SQ every 2 Weeks				QTY: <u>2</u>	Refills: _____

Prescriber's Signature: _____ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

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