

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____
 Other: _____ Date: _____
 Diagnosed by: Endoscopy CT Scan
 Assessment: Moderate Moderate to Severe Severe
 Number of severe exacerbations in the past 12 months that required systemic corticosteroids, ER visits or hospitalizations: _____
 Blood Eosinophil Level: _____ Test Date: _____
 IgE Level (if atopic comorbidities) : _____ Test Date: _____

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> Biologics	_____
<input type="checkbox"/> ICS	_____
<input type="checkbox"/> ICS + LABA	_____
<input type="checkbox"/> Intranasal Corticosteroids	_____
<input type="checkbox"/> Injectable Corticosteroids	_____
<input type="checkbox"/> LABA	_____
<input type="checkbox"/> Oral Corticosteroids	_____
<input type="checkbox"/> Other Controllers	_____
<input type="checkbox"/> Sinus Surgery	_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: To Be Administered by Pharmacist (State of Missouri Only) Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> DUPIXENT®	<input type="checkbox"/> 200mg/1.14ml Prefilled Syringe	For adults and adolescents 12 years of age and older:		
		<input type="checkbox"/> Induction Dose: Inject 400mg SC on day one	2	0
		<input type="checkbox"/> Maintenance: Inject 200mg SC every other week	2	
	<input type="checkbox"/> 300mg/2ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 600mg SC on day one	2	0
	<input type="checkbox"/> Maintenance: Inject 300mg SC every other week	2		
		For adults with chronic rhinosinusitis with nasal polyposis:		
		<input type="checkbox"/> Inject 300mg SC every other week	2	
<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>				
<input type="checkbox"/>				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ 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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