Prescription & Enrollment Form

Dupixent® (dupilumab)

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name ______

Last name ______ Middle initial ______

Date of birth ______ ❑ Male ❑ Female Last 4 digits of SSN ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Parent/guardian (if applicable) ______

Home phone ______

Work phone ______

Cell phone ______

Evening phone ______

E-mail address ______

Patient's primary language: ❑ English ❑ Other

If other, please specify ______

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ______

Phone ______

Insured's name ______

Insured's employer ______

Relationship to patient ______

Identification # ______

Policy/group # ______

Prescription card: ❑ Yes ❑ No If yes, carrier ______

Policy # ______

Group # ______

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______

Prescriber's first name ______ Last name ______

Prescriber's title ______

If NP or PA, under direction of Dr. ______

Office contact and title ______

Office contact email ______

Office/clinic/institution name ______

Clinic/hospital affiliation ______

Street address ______ Suite # ______

City ______ State ______ Zip ______

Phone ______ Fax ______

NPI # ______ License # ______

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic

Clinic location ______

3 CLINICAL INFORMATION

Primary ICD-10 code: ______

❑ NKDA ❑ Known drug allergies ______

Prior anaphylactic reaction: ❑ Yes (Reason/date ______) ❑ No

Concurrent meds ______

Estimated % BSA involvement ______

Concomitant therapies: ❑ Short-acting beta agonist ❑ Long-acting beta agonist ❑ Antihistamines ❑ Decongestants ❑ Immunotherapy ❑ Inhaled corticosteroid ❑ Leukotriene modifiers ❑ Oral steroids ❑ Nasal steroids Other ______

Lab results: ❑ History of positive skin OR RAST test to a perennial aeroallergen

Pre-treatment steroid dose ______ mg

Pre-treatment serum IgE level ______ IU per mL Test date ______

Pre-treatment serum eosinophils ______ cells/mcL

and/or sputum eosinophils ______ Date ______

Patient wt ______ kg Date wt obtained ______

MD Specialty (required): ❑ Allergist ❑ Pulmonologist ❑ ENT ❑ Primary care ❑ Pediatrician ❑ Dermatologist ❑ Other ______

Prescription type: ❑ Naïve/new start ❑ Restart ❑ Continued therapy

Prior therapies: Please fax detailed medication history with dates of use as available. Required by some plan authorization criteria.

❑ Topical steroid(s) ❑ Oral antihistamines ❑ Topical PDE-4 inhibitor

❑ Oral steroids ❑ Oral immunosuppressants ❑ Topical calcineurin inhibitor

❑ Sinus surgery

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation and Directions	Quantity/Refills
Dupixent® (dupilumab) 200 mg/1.14 mL prefilled syringe 2-pack ❑ Asthma	❑ **Starter Dose:** Administer two syringes (total of 400 mg) subcutaneously on Day 1 then one syringe (200 mg) every 2 weeks starting on day 15 and thereafter. ❑ **Maintenance Dose:** Administer 200 mg under the skin every 2 weeks.	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
Dupixent® (dupilumab) 300 mg/2 mL prefilled syringe 2-pack ❑ Asthma ❑ Atopic Dermatitis	❑ **Starter Dose:** Administer two syringes (total of 600 mg) subcutaneously on Day 1 then one syringe (300 mg) every 2 weeks starting on day 15 and thereafter. ❑ **Maintenance Dose:** Administer 300 mg under the skin every 2 weeks.	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
Dupixent® (dupilumab) 300 mg/2 mL prefilled syringe 2-pack ❑ Chronic Rhinosinusitis With Nasal Polyposis	❑ Administer 300 mg under the skin every 2 weeks	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

______ Date ______ Substitution allowed ______ Date ______ Dispense as written

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to your team at 866.531.1025. To reach your team, call toll-free 866.839.2162.

You can now track shipments for all your Accredo patients. Go to https://prescribers.accredo.com and click "Help" to register.

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