Dupixent® Infusion Form

Fax Referral To:
877-438-9380

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: ________________ Next Infusion Date: ________________

Patient Information

Patient Name: ______________________ DOB: ____________ Sex: M F Height: _____ Weight: ____________

Phone Number: ____________________ Email Address: ______________________________

Allergies: ________________________________ Is the patient Diabetic: Y N ICD-10 Code: ________________

Emergency Contact: ______________________________ Phone Number: ______________________________

Primary Diagnosis: ________ Severe persistent asthma, uncomplicated ________ Severe persistent asthma with acute exacerbation

________ Polyarteritis with lung involvement [Churg-Strauss] ________ Moderate Persistent Asthma, Uncomplicated

________Other: ______________________________

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis, Including pulmonary function tests and CBC with diff. 2.Recent Labs, Eosinophil Count: __________ cells/μL Date of Test: __________ 3. Copy of the patient's Insurance Card

Lab Orders: ____

Physician Information

Prescribing Physician: ______________________ Practice Name: ______________________

Practice Phone: ______________________ Practice Fax: ______________________

Email: ______________________ Office Contact: ______________________

Co-managing Physician: ______________________ Phone/Email: ______________________

Medication Order

Medication: **Dupixent (dupilumab)**

New Start: ________ # Refills (Recommend 2 Refills)

400 mg SIG: 2 (200 mg/1.14 mL) injections SQ on Day 1
600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
Other: ______________________________ ________ # Refills (Recommend 2 Refills)

Maintenance Dose:

(200 mg/1.14 mL) injection SQ every 2 weeks, starting on Day 15
(300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15
Other: ______________________________

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

______________________ ______________________________
Physician's NPI# Physician's Address

______________________________ ______________________
Prescriber's Signature Date

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