

**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: \_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

**Diagnosis of moderate-to-severe asthma in patients ≥12 years old**  
 **Diagnosis of moderate-to-severe eosinophilic asthma in patients ≥12 years old**

Diagnosed by:  Pulmonary Function Test  Eosinophilic Level 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: \_\_\_\_\_

Pulmonary Function Test Results:

Pre-bronchodilator FEV1: \_\_\_\_\_ Test Date: \_\_\_\_\_

FeNO levels (if applicable): \_\_\_\_\_ Test Date: \_\_\_\_\_

**Prior Failed Treatments:**

- Biologics
- ICS
- ICS + LABA
- LABA
- Nebulizer
- Oral Corticosteroids
- Other

**Indicate Drug Name and Length of Treatment:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) in patients ≥18 years old**

Diagnosed by:  Rhinoscopy  Nasal endoscopy  CT Scan  
 Documentation of Ongoing Symptoms?  
 Nasal Obstruction or Discharge  Facial Pain or Pressure  
 Reduction in or Loss of Smell  N/A

Results and date of last CT scan or endoscopy, including polyp location/catheterization, if applicable: \_\_\_\_\_ Test Date: \_\_\_\_\_

History of Nasal Surgeries and Procedures?  Yes  No

Endoscopic Polyp Removal (Polypectomy)  
 Functional Endoscopic Sinus Surgery (FESS)

Other: \_\_\_\_\_

If no, reason(s) patient may not be a candidate for surgery: \_\_\_\_\_

**Prior Failed Treatments:**

- Oral Corticosteroids
- Intranasal Corticosteroids
- Medicated or Saline Nasal Rinse
- Surgery
- Other

**Indicate Drug Name and Length of Treatment:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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  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"/> <b>DUPIXENT®</b>	<input type="checkbox"/> 200mg/1.14ml single-dose prefilled pen <input type="checkbox"/> 200mg/1.14ml single-dose prefilled syringe <input type="checkbox"/> 300mg/2ml single-dose prefilled syringe <input type="checkbox"/> 300mg/2ml single-dose prefilled pen <input type="checkbox"/> 100mg/0.67ml single-dose prefilled syringe	<b>For adults and adolescents 12 years of age and older:</b> <input type="checkbox"/> <b>Induction Dose:</b> Inject 400mg SC on day one <input type="checkbox"/> <b>Maintenance:</b> Inject 200mg SC every other week	2	0
		<input type="checkbox"/> <b>Induction Dose:</b> Inject 600mg SC on day one <input type="checkbox"/> <b>Maintenance:</b> Inject 300mg SC every other week	2	0
		<b>For pediatric patients 6 to 11 years of age:</b> Initial dose and maintenance doses: <input type="checkbox"/> For 15kg or <30kg: <input type="checkbox"/> 100mg SC every other week <input type="checkbox"/> 300mg SC every four week <input type="checkbox"/> For ≥30kg: 200mg SC every other week	2	
		No initial loading dose is recommended for pediatric patients (6 to 11 years of age) with asthma.	1	
		<b>For adults with chronic rhinosinusitis with nasal polyposis:</b> <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.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.