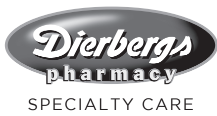

SPECIALTY CARE

ASTHMA SPECIALTY CARE PROGRAM

Phone: **844-283-6308** • Fax: **844-965-9849**

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: ____________

v9.0_120618

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

Date of Diagnosis: ______________ ICD-10: ____________

Other: ______________________ Date: ____________

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:
❑ Biologics	______________
❑ ICS	______________
❑ ICS + LABA	______________
❑ LABA	______________
❑ Oral/Injectable Corticosteroids	______________
❑ Other Controllers	______________

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

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ 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
❑ DUPIXENT®		**For adults and adolescents 12 years of age and older:**		
	❑ 200mg/1.14ml Prefilled Syringe	❑ **Induction Dose:** Inject 400mg SC on day one	2	0
		❑ **Maintenance:** Inject 200mg SC every other week	2	
	❑ 300mg/2ml Prefilled Syringe	❑ **Induction Dose:** Inject 600mg SC on day one	2	0
		❑ **Maintenance:** Inject 300mg SC every other week	2	
		For patients who require concomitant oral corticosteroids or with comborbid 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		
❑ ________	________	________		
❑ ________	________	________		

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: ________
Substitution Permitted

Signature: ______________________ Date: ________
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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