Dupixent®Infusion Form

Fax Referral To: 877-438-9380

ContinuumRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

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 ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date