



ASTHMA SPECIALTY CARE PROGRAM

Phone: 844-223-7510

Fax: 844-673-6161

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: _____
 Office Contact: _____ Phone: _____
 Email: _____

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:
<input type="checkbox"/> Biologics	_____
<input type="checkbox"/> ICS	_____
<input type="checkbox"/> ICS + LABA	_____
<input type="checkbox"/> LABA	_____
<input type="checkbox"/> Oral/Injectable Corticosteroids	_____
<input type="checkbox"/> Other Controllers	_____

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 REQUIRED INFORMATION: Front & back copies of pharmacy & medical cards along with charts & labs from last 90 days

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"/> DUPIXENT®	<input type="checkbox"/> 200mg/1.14ml Prefilled Syringe	For adults and adolescents 12 years of age and older:			
		<input type="checkbox"/> Induction Dose: Inject 400mg SC on day one	2	0	
	<input type="checkbox"/> 300mg/2ml Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject 200mg SC every other week		2	
		<input type="checkbox"/> Induction Dose: Inject 600mg SC on day one	2	0	
		<input type="checkbox"/> Maintenance: 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"/>	_____	_____			
<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.

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