DUPIXENT INJECTION ORDER (DUPILUMAB)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight: _____ lbs / kg

Allergies: _____

MEDICAL INFORMATION

ICD-10 & Diagnosis:

- ☐ J45.50: Severe persistent asthma, uncomplicated
- ☐ J44.9: Chronic Obstructive Pulmonary Disease (COPD), unspecified
- ☐ Other: _____

DUPIXENT THERAPY ORDER

- ☐ Dupixent 400mg subQ initially (two syringes of 200mg each will be administered)
- ☐ Dupixent 600mg subQ initially (two syringes of 300mg each will be administered)
- ☐ Dupixent 200mg subQ every 2 weeks
- ☐ Dupixent 300mg subQ every 2 weeks

Duration: ☐ X 6 months ☐ X 1 year ☐ _____ doses

Start Date of Infusion: ___/___/___ End Date: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____

Provider's NPI: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE FAX COMPLETED FORM, CLINICAL DOCUMENTATION, DEMOGRAPHICS & COPY OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994