

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL
1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name _____ Address _____ City, State, ZIP _____

Preferred Contact Methods _____ Phone (to primary # provided below) _____ Text (to cell # provided below) _____ Email (to email provided below) _____

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone _____ Alternate Phone _____ Date of Birth _____ Gender _____ Male _____ Female _____

Email _____ Last Four of SSN _____ Primary Language _____

2 PRESCRIBER INFORMATION

Prescriber's Name _____ State License Number _____

NPI Number _____ DEA Number _____ Group or Hospital _____

Address _____ City, State, ZIP _____

Phone _____ Fax _____ Contact Person _____ Contact's Phone _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date _____ Ship to _____ Patient _____ Office _____ Other _____

Diagnosis (ICD-10):

L20.9 Atopic Dermatitis, Unspecified _____ Other Code _____ Description _____

Patient Clinical Information

Allergies _____ Weight _____ lb/kg Height _____ in/cm TB Test Result _____ Date _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
Dupixent®	Carton of two 300 mg/2 mL solution pre-filled syringes with needle shield	Initial Dose: Inject 600 mg SC (two 300 mg injections in different injection sites) initially, then 300 mg SC every other week. Maintenance Dose: Inject 300 mg (one injection) SC every other week.	Quantity _____ Refills _____
Other	Other	Other:	Quantity _____ Refills _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(DATE)

DISPENSE AS WRITTEN

(DATE)

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