Please fax both pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Dupixent® (dupilumab)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

New patient   Current patient

Patient's first name ______ Last name ______ Middle initial ______

Sex at birth: Male Female Preferred pronouns ______ Last 4 digits of SSN ______ Date of birth ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ E-mail address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ E-mail address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ E-mail address ______

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify ______

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______

Office/clinic/institution name ______

Prescriber info: Prescriber's first name ______ Last name ______

Prescriber's title ______ If NP or PA, under direction of Dr. ______

Office phone ______ Fax ______ NPI # ______ License # ______

Office contact and title ______ Office contact e-mail ______

Office street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name ______ Clinic/hospital affiliation ______

Site street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion site contact ______ Phone ______ Fax ______ E-mail ______

3 Clinical Information

ICD-10 code (REQUIRED): ______

NKDA Known drug allergies ______

Prior anaphylactic reaction: Yes (Reason/date ______) No

Concurrent meds ______ Estimated % BSA involvement ______

Concomitant therapies: Short-acting beta agonist Long-acting beta agonist Antihistamines Decongestants Immunotherapy
Inhaled corticosteroid Leukotriene modifiers Oral steroids Nasal steroids Other ______

Lab results: History of positive skin OR RAST test to a perennial aeroallergen

Pre-treatment steroid dose ______ mg Pre-treatment serum IgE level ______ IU per mL Test date ______

Pre-treatment serum eosinophils ______ cells/mcL and/or sputum eosinophils ______ Date ______

Patient wt ______ kg Date wt obtained ______

MD Specialty (required): Allergist Pulmonologist ENT Primary care Pediatrician Dermatologist Other ______

Prescription type: Naïve/new start Restart Continued therapy

Prior therapies: Please fax detailed medication history with dates of use as available. Required by some plan authrization criteria.
Topical steroid(s) Oral antihistamines Topical PDE-4 inhibitor Oral steroids Oral immunosuppressants
Topical calcineurin inhibitor Sinus surgery

Patient's first name ______ Last name ______ Middle initial ______ Date of birth ______

Prescriber's first name ______ Last name ______ Phone ______

4 Prescribing Information

Medication	Strength / Formulation and Directions	Quantity/Refills
Dupixent® (dupilumab) 100mg/0.67mL prefilled syringe 2-pack Dupixent® (dupilumab) 200mg/1.14mL auto-injector pen 2-pack Dupixent® (dupilumab) 200mg/1.14mL prefilled syringe 2-pack Dupixent® (dupilumab) 300mg/2mL auto-injector pen 2-pack Dupixent® (dupilumab) 300mg/2mL prefilled syringe 2-pack	**Starter Dose:** Inject 400mg under the skin on Day 1 then 200mg every 2 weeks starting on day 15 and thereafter. **Maintenance Dose:** Inject 200mg under the skin every 2 weeks. **Starter Dose:** Inject 600mg under the skin on Day 1 then 300mg every 2 weeks starting on day 15 and thereafter. **Maintenance Dose:** Inject 300mg under the skin every 2 weeks. **Starter Dose:** Inject 600mg under the skin on Day 1 then 300mg every 4 weeks thereafter starting on day 29. **Maintenance Dose:** Inject 300mg under the skin every 4 weeks.	**Starter dose:** Quantity ______ No refills **Maintenance dose:** Quantity ______ Refills ______
	For indications without a starter dose: Inject 100mg under the skin every 2 weeks Inject 200mg under the skin every 2 weeks Inject 200mg under the skin every 4 weeks Inject 300mg under the skin once weekly Inject 300mg under the skin every 2 weeks Inject 300mg under the skin every 4 weeks	**For indications without a starter dose:** Quantity ______ Refills ______ Patient weight ______ kg

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

______ **Date** ______ **Dispense as written** ______ **Date** ______ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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