Please fax both pages of completed form to your team at 866.531.1025.
To reach your team, call toll-free 866.839.2162.
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®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

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

❑ Male ❑ Female 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 _____

Prescriber's first name _____ Last name _____

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

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic Clinic location _____

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) 200mg/1.14mL prefilled syringe 2-pack ❑ Asthma ❑ Atopic Dermatitis	❑ **Starter Dose:** Administer two syringes (total of 400mg) subcutaneously on Day 1 then one syringe (200mg) every 2 weeks starting on day 15 and thereafter. ❑ **Maintenance Dose:** Administer 200mg under the skin every 2 weeks.	❑ 1-month supply ❑ 3-month supply ❑ Other: _____ Refills _____
❑ Dupixent® (dupilumab) 300mg/2mL prefilled syringe 2-pack ❑ Asthma ❑ Atopic Dermatitis	❑ **Starter Dose:** Administer two syringes (total of 600mg) subcutaneously on Day 1 then one syringe (300mg) every 2 weeks starting on day 15 and thereafter. ❑ **Maintenance Dose:** Administer 300mg under the skin every 2 weeks.	❑ 1-month supply ❑ 3-month supply ❑ Other: _____ Refills _____
❑ Dupixent® (dupilumab) 300mg/2mL prefilled syringe 2-pack ❑ Chronic Rhinosinusitis With Nasal Polyposis	❑ **Starter Dose:** Administer two syringes (total of 600mg) subcutaneously on Day 1 then one syringe (300mg) every 2 weeks starting on day 15 and thereafter. ❑ Administer 300mg under the skin every 2 weeks	❑ 1-month supply ❑ 3-month supply ❑ Other: _____ Refills _____

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 (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)** PHYSICIAN SIGNATURE REQUIRED

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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