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 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. **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	**Starter dose:** Quantity _____ No refills **Maintenance dose:** Quantity _____ Refills _____ **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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