Please fax all 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.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Dupixent® (dupilumab)

EVERNORTH HEALTH SERVICES

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

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

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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 email _____

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 _____ Email _____

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 _____

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

Prescriber's first name _____ Last name _____ Phone _____

3 Clinical Information (cont.)

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 authorization criteria.

☐ Topical steroid(s) ☐ Oral antihistamines ☐ Topical PDE-4 inhibitor ☐ Oral steroids ☐ Oral immunosuppressants

☐ Topical calcineurin inhibitor ☐ Sinus surgery

4 Prescribing Information

Medication	Strength / Formulation	Directions	Quantity/Refills
Dupixent® (dupilumab)	☐ 200mg/1.14mL pre-filled pen (2-pack) ☐ 200mg/1.14mL pre-filled syringe (2-pack) ☐ 300mg/2mL pre-filled pen (2-pack) ☐ 300mg/2mL pre-filled syringe (2-pack)	**Starter Dose:** **If starter dose is NOT needed, DO NOT complete this section.** ☐ Inject 400mg under the skin on Day 1 then 200mg every 2 weeks starting on day 15 and thereafter. ☐ Inject 600mg under the skin on Day 1 then 300mg every 2 weeks starting on day 15 and thereafter. ☐ Inject 600mg under the skin on Day 1 then 300mg every 4 weeks thereafter starting on day 29. **Maintenance Dose:** ☐ Inject 200mg under the skin every 2 weeks. ☐ Inject 300mg under the skin every 2 weeks. ☐ Inject 300mg under the skin every 4 weeks. **No starter dose indicated or required:** ☐ 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:** Qty 1 (2-pack) No refills **Maintenance dose:** Days supply _____ Refills _____ **For orders without a starter dose:** Days supply _____ Refills _____ Patient weight _____ kg
☐ Other			

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.

EVERNORTH HEALTH SERVICES