

PRESCRIPTION ORDER FORM

DUPIXENT (dupilumab)



Central Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- Progress Note
- Demographics

PRIMARY DIAGNOSIS

- | | |
|---|---|
| ☐ L20.9 Atopic dermatitis, unspecified | ☐ K20.0 Eosinophilic esophagitis |
| ☐ J45.40/J45.41 Moderate persistent Asthma | ☐ L28.1 Prurigo nodularis |
| ☐ J45.50/J45.51 Severe persistent asthma | ☐ J44.9 COPD, unspecified |
| ☐ J82.83 Eosinophilic asthma | ☐ L50.8 Other urticaria |
| ☐ J33.0 Polyp of nasal cavity | ☐ L50.9 Urticaria, unspecified |
| ☐ J33.9 Nasal polyp, unspecified | ☐ L12.0 Bullous pemphigoid |
| | ☐ Other: _____ |

CLINICAL MONITORING

Consider completing all age-appropriate vaccinations as recommended by current immunization guidelines

PRIMARY MEDICATION ORDER ** If necessary, Suite Life will round dose up/down according to payor guidelines**

Please fill in correct dosing based on diagnosis, age and weight

Loading dose:

- ☐ _____mg subcutaneous injection
- ☐ No loading dose

Maintenance dose:

_____mg subcutaneous injection every _____ weeks

LINE USE/CARE ORDERS

- ☒ Start PIV/ACCESS CVC ☒ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol
(See suitelifehealth.com for detailed policy)
- ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date

Rev: 9/25