

Dupixent (Dupilumab) Injection Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code): _____

Other: _____

NKDA Allergies: _____

New Therapy Order Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication:

- Acetaminophen _____mg by PO
- Cetirizine _____mg by PO
- Diphenhydramine _____mg by PO/ IVP
- Solu-Medrol _____mg by PO/ IVP
- Solu-Cortef _____mg by PO/ IVP
- Other: _____

Required Documentation:

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Other: _____

Patient height and weight:

Patient Height (cm): _____

Patient Weight (kg): _____

Dupixent Medication Order (Please select ONE):

- Subcutaneous Induction dosing on initial week, followed by maintenance

- Dosing (Please choose one)

- 200mg
- 300mg
- 400mg
- 600mg
- Other: _____

- Maintenance Frequency (Please choose one)

- Every 2 weeks
- Every 4 weeks
- Other: _____

- Subcutaneous Maintenance dosing every ____ weeks only

- Dosing (Please choose one)

- 200mg
- 300mg
- 400mg
- 600mg
- Other: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____

Date: _____

Provider: _____

Phone: _____ Fax: _____

Best Contact Person in Office: _____

Phone: _____

Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400