PROFESSIONAL PHARMACY GROUP
Specialty Pharmacy

ASTHMA SPECIALTY PROGRAM

Phone: 844-223-7510
Fax: 844-673-6161

PATIENT INFORMATION:

Name: _____ Address: _____

City: _____ State: ____ Zip: _____ Phone: _____ Alt. Phone: _____

Email: _____ DOB: _____ Gender: _____ Height: _____

Weight: _____ Allergies: _____

PRESCRIBER INFORMATION:

Name: _____ Address: _____

City: _____ State: ____ Zip: _____ Phone: _____ Fax: _____

NPI: _____ DEA: _____ Tax I.D.: _____

Office Contact: _____ Phone with Extension: _____

STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: _____ Primary ICD-10: _____ Secondary ICD-10: _____

Blood Eosinophil Level: _____ Test Date: _____ IgE Level: _____ Test Date: _____

Number of exacerbations in the last 12 months: _____

PRIOR TREATMENTS AND DATES OF THERAPY: _____

_____

REQUIRED INFORMATION: Please fax copy of ***Prescription and Insurance Cards*** (front and back), as well as ***Clinical Chart Notes and Labs/Test Results***

PRESCRIPTION INFORMATION:

Patient Name: _____ Date of Birth: _____

Medication	Strength	Directions	Quantity/Refills
☐ **Dupixent (dupilumab)**	☐ **200 mg/1.14ml PFS*** ☐ **300 mg/2mL PFS*** ***Come in cartons of 2 PFS**	**Asthma Initial Dose:** ☐ Inject 400mg SC (2-200mg injections in different injection sites) initially then 200mg SC every other week ☐ Inject 600mg SC (2-300mg injections in different injection sites) initially then 300mg SC every other week **Asthma Maintenance Dose:** ☐ Inject 200mg (one injection) SC every other week ☐ Inject 300mg (one injection) SC every other week **Chronic Sinusitis with Nasal Polyposis:** ☐ Inject 300mg (one injection) SC every other w eek	Quantity: _____ Refills:_____

PHYSICIAN SIGNATURE REQUIRED:

SIGNATURE: _____ **DATE:** _____