

Prescriber Information

Prescriber Name:			MD		DO		NP		PA		NPI:		
Office Contact:						Practice Name / Collaborating MD:							
Address:				City:				State:				Zip:	
Phone:			Fax:										

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient Name:			Last 4 Digits of SS#:			DOB: / /			Sex: M F		Weight:		Height:		Diabetic? Y N	
Address:				City:				State:				Zip:				
Home Phone:			Work/Cell:			HIPAA Contact:				Emergency #:						
Interpreter Needed? Y N		Allergies: Y N If Yes, list allergies:														

Insurance Information

Primary Insurance:			Policy ID:			Group #:			BIN:			PCN:		
Policyholder Name:						Policyholder DOB: / /								

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:		Pulmonary Eosinophilia (J82)		Moderate Persistent Asthma, uncomplicated (J45.40)		Severe Persistent Asthma, uncomplicated (J45.50)		Idiopathic Urticaria (L50.1)									
Atopic Dermatitis (L20.9)		Nasal Polyp (J33._____)		Eosinophilic esophagitis (K20)		Other:				FEV1: %							
Pre-treatment serum IgE:		< 30 IU/mL		≥30-100 IU/mL		> 100-200 IU/mL		> 200-300 IU/mL		> 300-400 IU/mL		> 400-500 IU/mL		> 500-600 IU/mL		> 600-700 IU/mL	
Patient medical history includes:		Positive RAST		Positive skin test to perennial aeroallergen		Asthma with eosinophilic phenotype		Other:									
Current maintenance treatment (include dose and frequency):												Patient is a smoker or is exposed to smoke in the home: Y N					
Current exacerbation treatment (include dose and frequency):																	
Prior Treatment? Y N		BSA Affected (%):		Affected Areas:		Palms		Soles		Head		Neck		Genitalia		Other:	
Notes to Pharmacy:																	

Prescription Information

Medication		Quantity/Dose		Sig				Refills
ADBRY™		1 carton (2x300mg/2ml) PEN 1 carton (4x150mg/mL) PFS		Starter Dose: Adults: Inject 600mg SQ at week 0. Begin maintenance dose at week 2. Pediatrics age ≥ 12: Inject 300mg SQ at week 0. Begin maintenance dose at week 2.				No Refills
		1 carton (2x300mg/2ml) PEN 1 carton (4x150mg/mL) PFS 1 carton (1x300mg/2ml) PEN 1 carton (2x150mg/mL) PFS		Adult Maintenance Dose: Inject 300mg SQ every other week Inject 300mg SQ every 4 weeks				Pediatrics Maintenance Dose: Pediatrics age ≥ 12: Inject 150mg SQ every other week
CIBINQO™		50mg tablet (30 day supply) 100mg tablet (30 day supply) 200mg tablet (30 day supply)		Take 1 tablet by mouth daily				
DUPIXENT® <i>*Asthma – Pediatrics (age 6-11)</i>	PFS Pen	1 carton (2x200mg/1.14ml) 1 carton (2x300mg/2ml)		Weight 15-29kg: Inject 300mg SQ every 4 weeks Weight ≥30kg: Inject 200mg SQ every other week				
DUPIXENT® <i>*Asthma & Chronic Idiopathic Urticaria - Adults & Pediatrics aged 12 and older</i>	PFS Pen	1 carton (2x200mg/1.14ml) 1 carton (2x300mg/2ml)		Starter Dose: Inject 400mg SQ at week 0. Begin maintenance dose at week 2. Inject 600mg SQ at week 0. Begin maintenance dose at week 2.				No Refills
		1 carton (2x200mg/1.14ml) 1 carton (2x300mg/2ml)		Maintenance Dose: Inject 200mg SQ every 2 weeks Inject 300mg SQ every 2 weeks				
DUPIXENT® <i>*Atopic Dermatitis – Pediatrics (age 6 months to 5 years)</i> <i>*Dupixent pens only for use in children aged 2 or older</i>	PFS Pen	1 carton (2x200mg/1.14ml) 1 carton (2x300mg/2ml)		Weight 5-14kg: Inject 200mg SQ every 4 weeks Weight 14-29kg: Inject 300mg SQ every 4 weeks				
		1 carton (2x200mg/1.14ml) 1 carton (2x300mg/2ml)		Starter Dose: Weight 15-29kg: Inject 600mg at week 0. Begin maintenance dose at week 4 Weight 30-59kg: Inject 400mg SQ at week 0. Begin maintenance dose at week 2. Weight ≥60kg: Inject 600mg SQ at week 0. Begin maintenance dose at week 2.				No Refills
DUPIXENT® <i>*Atopic Dermatitis - Pediatrics (age 6 & older)</i>	PFS Pen	1 carton (2x200mg/1.14ml) 1 carton (2x300mg/2ml)		Maintenance Dose: Weight 15-29kg: Inject 300mg SQ every 4 weeks Weight 30-59kg: Inject 200mg SQ every 2 weeks Weight ≥60kg: Inject 300mg SQ every 2 weeks				
		1 carton (2x200mg/1.14ml) 1 carton (2x300mg/2ml)		Starter Dose: Inject 600mg SQ at week 0. Begin maintenance dose at week 2.				No Refills
DUPIXENT® <i>*Atopic Dermatitis - Adults</i>	PFS Pen	1 carton (2x300mg/2ml)		Maintenance Dose: Inject 300mg SQ every other week				
		1 carton (2x300mg/2ml)		Inject 300mg SQ every 2 weeks				
DUPIXENT® <i>*Chronic Rhinosinusitis with Nasal Polyps</i>	PFS Pen	1 carton (2x300mg/2mL)		Inject 300mg SQ every 2 weeks				
DUPIXENT® <i>*Eosinophilic Esophagitis (Adults and Pediatrics 1 year & older)</i> <i>*Dupixent pens only for use in children aged 2 or older</i>	PFS Pen	1 carton (2x200mg/1.14ml) 1 carton (2x300mg/2ml) 2 cartons (4x300mg/2ml)		Weight 15-29kg: Inject 200mg SQ every other week Weight 30-39kg: Inject 300mg SQ every other week Weight ≥40kg: Inject 300mg SQ once weekly				

Injection Training

Patient received injection training		Prescriber's office to provide injection training		Meijer to coordinate injection training	
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By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature		Date		Prescriber Signature		Date	
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Substitution Permitted

Dispense as Written