

**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**

Patients Name:		Last 4 Digits of SS#:		DOB: / /	Sex: M F	Weight:	Height:	Diabetic? Y N
Office Contact:				Practice Name / Collaborating MD:				
Address:			City:		State:		Zip:	
Home Phone:		Work/Cell:		HIPPA 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._____)		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 (Provide Information Below)	BSA Affected (%):		Affected Areas: Palms Soles Head Neck Genitalia Other:					
Prior Therapy:			Reason for Discontinuation of Therapy:				Approx. Start Date: / /	
							Approx. End Date: / /	
Comorbidities:				Concomitant Medications:				

**Prescription Information**

Medication	Quantity/Dose	Sig	Refills
<b>CIBINQO™</b>	50mg tablet (30 day supply) 100mg tablet (30 day supply) 200mg tablet (30 day supply)	Take 1 tablet by mouth daily	
<b>DUPIXENT®</b> <i>*Asthma</i> <i>*Dupixent pens only for use in adolescents aged 12 and older</i>	PFS Pen 1 carton (2x300mg/2mL) 1 carton (2x200mg/1.14mL) 1 carton (2x100mg/0.67mL)	<b>Starter Dose: Adults and Adolescents 12 years and older:</b> Inject 400mg SQ at week 0. Begin maintenance dose at week 2. Inject 600mg SQ at week 0. Begin maintenance dose at week 2.  <b>Maintenance Dose: Adults and Adolescents 12 years and older:</b> Inject 200mg SQ every 2 weeks Inject 300mg SQ every 2 weeks  <b>Pediatrics 6-11 years:</b> <u>Weight ≥30kg:</u> Inject 200mg SQ every other week <u>Weight 15 to &lt;30kg:</u> Inject 100mg SQ every other week Inject 300mg SQ every 4 weeks	<b>No Refills</b>
<b>DUPIXENT®</b> <i>*Atopic Dermatitis</i> <i>*Dupixent pens only for use in adolescents aged 12 and older</i>	PFS Pen 1 carton (2x200mg/1.14mL) 1 carton (2x300mg/2mL)  1 carton (2x200mg/1.14mL) 1 carton (2x300mg/2mL)	<b>Starter Dose: Adults:</b> Inject 600mg SQ at week 0. Begin maintenance dose at week 2.  <b>Maintenance Dose: Adults:</b> Inject 300mg SQ every other week  <b>Pediatrics age 6 years and older:</b> <u>Weight 15-29kg:</u> Inject 600mg SQ at week 0. Begin maintenance dose at week 4. <u>Weight 30-59kg:</u> Inject 400mg SQ at week 0. Begin maintenance dose at week 2. <u>Weight ≥60kg:</u> Inject 600mg SQ at week 0. Begin maintenance dose at week 2.  <b>Pediatrics age 6 years and older:</b> <u>Weight 15-29kg:</u> Inject 300mg SQ every 4 weeks <u>Weight 30-59kg:</u> Inject 200mg SQ every 2 weeks <u>Weight ≥60kg:</u> Inject 300mg SQ every 2 weeks	<b>No Refills</b>
<b>DUPIXENT®</b> <i>*Chronic Rhinosinusitis with Nasal Polyps</i>	PFS Pen 1 carton (2x300mg/2mL)	Inject 300mg SQ every 2 weeks	
<b>DUPIXENT®</b> <i>*Eosinophilic Esophagitis</i>	PFS Pen 2 cartons (4x300mg/2mL)	Inject 300mg SQ once weekly	
<b>FASENRA®</b>	1 carton (30mg/mL) PFS 1 carton (30mg/mL) PEN  1 carton (30mg/mL) PFS 1 carton (30mg/mL) PEN	<b>Starter Dose:</b> Inject 30mg SQ every 4 weeks for the first 3 doses  <b>Maintenance Dose:</b> Inject 30mg SQ every 8 weeks	<b>2</b>

**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