**Community Memorial Pharmacy**
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose** **Allergy/Asthma (A-D) Cibinqo™, Dupixent®**

## 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's 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) _____
Current exacerbation treatment (include dose and frequency) _____
Patient is a smoker or is exposed to smoke in the home ☐ Y ☐ N
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 _____

Community Memorial HEALTHCARE

## Prescription Information

| Medication | Quantity/Dose | Sig | Refills |
|---|---|---|---|
| ☐ **CIBINQO™** | ☐ 50 mg tablet (30 day supply)<br>☐ 100 mg tablet (30 day supply)<br>☐ 200 mg tablet (30 day supply) | ☐ Take 1 tablet by mouth daily | |
| ☐ **DUPIXENT®** ☐ PFS<br>*Asthma – Pediatrics (age 6-11) ☐ Pen | ☐ 1 carton (2x200 mg/1.14 ml)<br>☐ 1 carton (2x300 mg/2 ml) | ☐ Weight 15-29 kg: Inject 300 mg SQ every 4 weeks<br>☐ Weight ≥30kg: Inject 200 mg SQ every other week | |
| ☐ **DUPIXENT®** ☐ PFS<br>*Asthma & Chronic Idiopathic Urticaria – Adults & Pediatrics aged 12 and older | ☐ 1 carton (2x200 mg/1.14 ml)<br>☐ 1 carton (2x300 mg/2 ml) | Starter Dose<br>☐ Inject 400 mg SQ at week 0. Begin maintenance dose at week 2.<br>☐ Inject 600 mg SQ at week 0. Begin maintenance dose at week 2. | No Refills |
| ☐ Pen | ☐ 1 carton (2x200 mg/1.14 ml)<br>☐ 1 carton (2x300 mg/2 ml) | Maintenance Dose<br>☐ Inject 200 mg SQ every 2 weeks<br>☐ Inject 300 mg SQ every 2 weeks | |
| ☐ **DUPIXENT®** ☐ PFS<br>*Atopic Dermatitis – Pediatrics (age 6 months to 5 years) ☐ Pen<br>*Dupixent pens only for use in children aged 2 or older | ☐ 1 carton (2x200 mg/1.14 ml)<br>☐ 1 carton (2x300 mg/2 ml) | ☐ Weight 5-14 kg: Inject 200 mg SQ every 4 weeks<br>☐ Weight 14-29 kg: Inject 300 mg SQ every 4 weeks | |
| ☐ **DUPIXENT®** ☐ PFS<br>*Atopic Dermatitis – Pediatrics (age 6 & older) ☐ Pen | ☐ 1 carton (2x200 mg/1.14 ml)<br>☐ 1 carton (2x300 mg/2 ml) | Starter Dose<br>☐ Weight 15-29 kg: Inject 600 mg at week 0. Begin maintenance dose at week 4<br>☐ Weight 30-59 kg: Inject 400 mg SQ at week 0. Begin maintenance dose at week 2.<br>☐ Weight≥60 kg: Inject 600 mg SQ at week 0. Begin maintenance dose at week 2. | No Refills |
| | ☐ 1 carton (2x200 mg/1.14 ml)<br>☐ 1 carton (2x300 mg/2 ml) | Maintenance Dose<br>☐ Weight 15-29 kg: Inject 300 mg SQ every 4 weeks<br>☐ Weight 30-59 kg: Inject 200 mg SQ every 2 weeks<br>☐ Weight≥60 kg: Inject 300 mg SQ every 2 weeks | |

Community Memorial HEALTHCARE

## Prescription Information

| Medication | Quantity/Dose | Sig | Refills |
|---|---|---|---|
| ☐ **DUPIXENT®** ☐ PFS ☐ Pen<br>*Atopic Dermatitis – Adults | ☐ 1 carton (2x300 mg/2 ml)<br>☐ 1 carton (2x300 mg/2 ml) | Starter Dose<br>☐ Inject 600 mg SQ at week 0. Begin maintenance dose at week 2.<br>Maintenance Dose<br>☐ Inject 300 mg SQ every other week | No Refills |
| ☐ **DUPIXENT®** ☐ PFS ☐ Pen<br>*Chronic Rhinosinusitis with Nasal Polyps | ☐ 1 carton (2x300 mg/2 mL) | ☐ Inject 300 mg SQ every 2 weeks | |
| ☐ **DUPIXENT®** ☐ PFS ☐ Pen<br>*Eosinophilic Esophagitis (Adults and Pediatrics 1 year & older)<br>*Dupixent pens only for use in children aged 2 or older | ☐ 1 carton (2x200 mg/1.14 ml)<br>☐ 1 carton (2x300 mg/2 ml)<br>☐ 2 cartons (4x300 mg/2 ml) | ☐ Weight 15-29 kg: Inject 200 mg SQ every other week<br>☐ Weight 30-39 kg: Inject 300 mg SQ every other week<br>☐ Weight≥40 kg: Inject 300 mg SQ once weekly | |

## Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____ *Substitution Permitted*
Date _____

Prescriber Signature _____ *Dispense as Written*
Date _____

If brand is required, please write "DAW" in the box to the right. ☐