MedPlus SPECIALTY

RESPIRATORY SPECIALTY CARE PROGRAM

Phone: **844-378-3784** • Fax: **888-972-7058**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Supervising Physician: _____ NPI: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ICD-10: _____ Secondary Diagnosis: _____ Date: _____

❑ **Diagnosis of moderate-to-severe asthma in patients ≥12 years old**
❑ **Diagnosis of moderate-to-severe eosinophilic asthma in patients ≥12 years old**

Diagnosed by: ❑ Pulmonary Function Test ❑ Eosinophilic Level
Assessment: ❑ Moderate ❑ Moderate to Severe ❑ Severe

Number of severe exacerbations in the past 12 months that required systemic corticosteroids, ER visits or hospitalizations: _____

Blood Eosinophil Level: _____ Test Date: _____
IgE Level (if atopic comorbidities) : _____Test Date: _____

Pulmonary Function Test Results:
Pre-bronchodilator FEV1: _____ Test Date: _____
FeNO levels (if applicable): _____ Test Date: _____

Prior Failed Treatments:	**Indicate Drug Name and Length of Treatment:**
❑ Biologics	_____
❑ ICS	_____
❑ ICS + LABA	_____
❑ LABA	_____
❑ Nebulizer	_____
❑ Oral Corticosteroids	_____
❑ Other	_____

❑ **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) in patients ≥18 years old**

Diagnosed by: ❑ Rhinoscopy ❑ Nasal endoscopy ❑ CT Scan
Documentation of Ongoing Symptoms?
❑ Nasal Obstruction or Discharge ❑ Facial Pain or Pressure
❑ Reduction in or Loss of Smell ❑ N/A

Results and date of last CT scan or endoscopy, including polyp location/catheterization, if applicable: _____ Test Date: _____

History of Nasal Surgeries and Procedures? ❑ Yes ❑ No
❑ Endoscopic Polyp Removal (Polypectomy)
❑ Functional Endoscopic Sinus Surgery (FESS)
❑ Other: _____
If no, reason(s) patient may not be a candidate for surgery:
_____

Prior Failed Treatments:	**Indicate Drug Name and Length of Treatment:**
❑ Oral Corticosteroids	_____
❑ Intranasal Corticosteroids	_____
❑ Medicated or Saline Nasal Rinse	_____
❑ Surgery	_____
❑ Other	_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ DUPIXENT®	❑ 300mg/2ml Prefilled Syringe ❑ 200mg/1.14ml Prefilled Pen ❑ 200mg/1.14ml Prefilled Syringe ❑ 300mg/2ml Prefilled Pen (only for 12 years and older)	**For adults and adolescents 12 years of age and older:** ❑ **Induction Dose:** Inject 400mg SC on day one ❑ **Maintenance:** Inject 200mg SC every other week ❑ **Induction Dose:** Inject 600mg SC on day one ❑ **Maintenance:** Inject 300mg SC every other week **For adults with chronic rhinosinusitis with nasal polyposis:** ❑ Inject 300mg SC every other week	2 2 2 2 2	0 0
		For patients who require concomitant oral corticosteroids or with comborbid moderate to severe atopic dermatitis for which Dupixent® is indicated, start with an initial dose of 600mg SC followed by 300mg SC given every other week		
❑ _____	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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