

Dupilumab (Dupixent)

Provider Order Form rev. 3/7/23



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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

0 TB status & date (list results here & attach clinicals)

0 Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

CBC at each dose every _____

CMP at each dose every _____

CRP at each dose every _____

Other: _____

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg / 50mg PO / IV

methylprednisolone (Solu-Medrol) 40mg / 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: _____

Dose: _____ Route: _____

Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

- Dupilumab**
 - Dose: 200mg/ 1.14mL pre-filled syringe 2-pack
 - Starter Dose: Administer two syringes (total of 400mg) SQ in different injection sites on Day 1, then one syringe (200mg SQ) every 2 weeks starting on day 15 and thereafter.
 - Maintenance Dose: Administer 300mg SQ every 2 weeks
 - Frequency: every week / every two weeks / other: _____

- Dupilumab**
 - Dose: 200mg/ 1.14mL pre-filled syringe 2-pack
 - Starter Dose: Administer two syringes (total of 600mg) SQ in different injection sites on Day 1, then one syringe (300mg SQ) every 2 weeks starting on day 15 and thereafter.
 - Maintenance Dose: Administer 200mg SQ every 2 weeks
 - Frequency: every week / every two weeks / other: _____

Provider Name
(Print)

Provider Signature

Date