TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

DUPIXENT ORDER FORM

Date: ____________________ ICD-10 Code: ____________________

Patient Name: ____________________ Allergies: ____________________

Date of Birth: ____________________ Weight: ________ lbs OR ________ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: ____________________

Provider Information

Ordering Provider: ____________________ Provider Fax: ____________________

Provider NPI: ____________________ Provider Address: ____________________

Provider Phone: ____________________

MEDICATION ORDER

Dupixent

☐ Administer Dupixent 600mg subcutaneously (two 300mg injections in different injection sites) followed by 300mg subcutaneously every other week per protocol.

☐ Administer Dupixent 400mg subcutaneously (two 200mg injections in different injection sites) followed by 200mg subcutaneously every other week per protocol.

☐ Administer Dupixent ________mg subcutaneously every ________ weeks per protocol.

Refills for one year from date of signature unless indicated below.

________ Refills

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: ______325mg ______500mg ______650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ______25mg ______50mg
- ☐ Famotidine: ______20mg ______40mg
- ☐ Ibuprofen: ______200mg ______400mg ______600mg
- ☐ Ondansetron: ______4mg ______8mg
- ☐ Other: ____________________

IV

- ☐ Dexamethasone: ______4mg ______8mg
- ☐ Diphenhydramine: ______25mg ______50mg
- ☐ Famotidine: ______20mg ______40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: ______4mg ______8mg
- ☐ Other: ____________________

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

____________________ ____________
Prescriber Name Date

Substitution Allowed:

____________________ ____________
Prescriber Name Date

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