NEWPORT INFUSION

DUPIXENT REFERRAL FORM

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NPI# 1184620866
newportinfusion.com

Today's Date _____

Date Needed _____

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female

Address_____ Apt #_____ City_____ State_____ Zip_____

Telephone_____ Cell_____ SSN_____ Email_____

Allergies_____ Comorbidities_____

Current Medications (including OTC, if necessary, please fax a complete list)_____

Primary Insurance_____ ID#_____ Group #_____

Secondary Insurance _____ ID# _____ Group # _____

Insured's Name _____ Employer _____

City _____ State _____ Phone _____ **Please attach patient's insurance cards, front and back**

Diagnosis ICD-10 Code: ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Other _____

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: _____Cells/μL Date of test:_____/_____/_____

Number of asthma exacerbations (requiring use of systemic corticosteroids and/or hospitalization) in last 12 months: _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS (front and back)

Medication	Directions	Quantity	Refills
Dupixent™ (dupilumab)	**Initiation Dose:**		
	☐ **400mg** (2 x 200mg injections) administered subcutaneously as a single dose	☐ 1	☐ 1
	☐ **600mg** (2 x 300mg injections) administered subcutaneously as a single dose	☐ _____	☐ 2
	Maintenance Dose:		☐ 3
	☐ **200mg** injection administered every other week	☐ 1	☐ 4
	☐ **300mg** injection administered every other week	☐ _____	☐ _____ # Refills

Has the patient been started on a samples? ☐ **Yes** ☐ **No**

Total number of DUPIXENT (dupilumab) doses received since start date: _____ Date of last injection/treatment:_____

Please attach the following: Most Recent Progress Notes & Lab Results (Eosinophil count) & Full Medication List

Thank you!

Prescriber's Name / Practice _____ Office Contact_____

Address_____ Suite#_____ City_____ State_____ Zip_____

Tel_____ Fax_____Email _____

License#_____ NPI#_____ UPIN#_____ DEA# _____

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to Newport Infusion at (949)484-4150