



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

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: _____ Cells/ μ L 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 TM (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
			☐ 3
	Maintenance Dose:		
	☐ 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 _____

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