**Cumberland Vital Care**
**Fax Referral To:**
**(931) 456-4857**
Direct Phone: (931) 456-0680

CVC CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

# DUPIXENT ORDER FORM

| | |
|---|---|
| Date: | ICD-10 Code: _____ |
| Patient Name: | Allergies: _____ |
| Date of Birth: | Weight: _____lbs OR _____kg |

| Therapy Status | Provider Information |
|---|---|
| New Start<br>Continuing Therapy:<br>Last Dose: _____ | Ordering Provider: _____<br>Provider NPI: _____<br>Provider Phone: _____<br>Provider Fax: _____<br>Provider Address: _____ |

## MEDICATION ORDER

| | | |
|---|---|---|
| Dupixent | Administer Dupixent 600mg subcutaneously (two 300mg injections in different injection sites) followed by 300mg subcutaneously every other week per protocol.<br><br>Administer Dupixent 400mg subcutaneously (two 200mg injections in different injection sites) followed by 200mg subcutaneously every other week per protocol.<br><br>Administer Dupixent _____mg subcutaneously every _____ weeks per protocol. | ***Refills x one year from date of signature unless indicated below.***<br><br>_____ Refills |

## PRE-MEDICATIONS

Oral
Acetaminophen: ___325mg ___500mg ___650mg
Loratadine: 10 mg
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 above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

| | |
|---|---|
| Dispense as Written: | Substitution Allowed: |
| _____ _____<br>Prescriber Name Date | _____ _____<br>Prescriber Name Date |