

PATIENT & PRESCRIBER

PATIENT NAME		DATE OF BIRTH	PHONE
WEIGHT — required for patients under 18		ALLERGIES	PATIENT STATUS
PRESCRIBER NAME	NPI #	PHONE	FAX
PRIMARY INSURANCE	POLICY #	GROUP #	START DATE REQUESTED

INDICATION & DIAGNOSIS

check the indication being treated, then the ICD-10 code

- | | |
|---|--|
| ☐ Atopic dermatitis L20.81 · L20.84 · L20.89 · L20.9
☐ Asthma J45.40 / .41 / .42 · J45.50 / .51 / .52
☐ Chronic rhinosinusitis with nasal polyps
J33.0 · J33.1 · J33.9 · J32.4 · J32.9
☐ Eosinophilic esophagitis K20.0 | ☐ Prurigo nodularis L28.1
☐ COPD, eosinophilic phenotype J44.0 · J44.1 · J44.9
☐ Chronic spontaneous urticaria L50.1
☐ Bullous pemphigoid L12.0
☐ Allergic fungal rhinosinusitis J32.4 · J33.9 |
|---|--|

ICD-10 CODE SELECTED	DIAGNOSIS DESCRIPTION
----------------------	-----------------------

DUPIXENT ORDER

write the dose the prescriber intends — see the reference table below

LOADING DOSE ☐ 600 mg ☐ 400 mg ☐ None ☐ _____ mg	MAINTENANCE DOSE ☐ 300 mg ☐ 200 mg ☐ Other: _____ mg	FREQUENCY ☐ Every 2 weeks ☐ Every 4 weeks ☐ Weekly ☐ Other: _____ Refills: ☐ × 1 year ☐ _____
---	--	--

INDICATION	AGE	LOADING DOSE	MAINTENANCE
Atopic dermatitis	Adults	600 mg	300 mg every 2 weeks
Asthma, eosinophilic phenotype	12 and older	400 mg or 600 mg	200 mg or 300 mg every 2 weeks
Asthma — OCS-dependent, or with atopic dermatitis or CRSwNP	12 and older	600 mg	300 mg every 2 weeks
Chronic rhinosinusitis with nasal polyps	12 and older	None	300 mg every 2 weeks
Eosinophilic esophagitis, 40 kg or more	1 and older	None	300 mg weekly
Prurigo nodularis	Adults	600 mg	300 mg every 2 weeks
COPD, eosinophilic phenotype	Adults	None	300 mg every 2 weeks
Chronic spontaneous urticaria	Adults	600 mg	300 mg every 2 weeks
Bullous pemphigoid — with a tapering oral steroid course	Adults	600 mg	300 mg every 2 weeks

Patients under 18, and eosinophilic esophagitis under 40 kg, are dosed by weight band. Record the weight above and write the intended dose in the order box — our pharmacist will confirm the band against current labeling.

ADMINISTRATION

Presentation	☐ Pre-filled pen ☐ Pre-filled syringe Strength: ☐ 300 mg ☐ 200 mg ☐ 100 mg
Administered by	☐ In clinic by LIVbetter ☐ Patient self-injects at home ☐ Caregiver Training visits: _____
Injection sites	Thigh or abdomen, avoiding 2 inches around the navel. Upper arm only when a caregiver or provider injects. Rotate sites. Allow the syringe or pen to reach room temperature before injecting.

Before starting: ☐ pre-existing helminth infection treated ☐ no live attenuated vaccines planned ☐ patient counseled that corticosteroids must not be stopped abruptly
Watch for conjunctivitis and keratitis, and for eosinophilic conditions including vasculitis consistent with EGPA. Not for acute bronchospasm or status asthmaticus.

Other orders	_____
Lab orders	Labs: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring

PRESCRIBER SIGNATURE

required — we cannot schedule without it

By signing, you authorize LIVbetter Infusions to act as your prior authorization and specialty pharmacy designated agent with insurance companies and to select the site of care.

PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

PATIENT NAME	DATE OF BIRTH

SEND WITH EVERY REFERRAL

- ☐ Signed and completed order (prescriber to complete page 1)
- ☐ Patient demographic and insurance information
- ☐ Current medication list
- ☐ Clinical notes supporting the diagnosis, including tried and failed therapies and intolerance
- ☐ Weight documented — required for every patient under 18

ATOPIC DERMATITIS • PRURIGO NODULARIS • BULLOUS PEMPHIGOID

- ☐ Body surface area involved: _____ % ☐ EASI or IGA score: _____
- ☐ Failed or intolerant to topical corticosteroids. Agent: _____
- ☐ Failed or intolerant to topical calcineurin inhibitor or crisaborole. Agent: _____
- ☐ Prurigo nodularis — number of nodules and duration: _____
- ☐ Bullous pemphigoid — biopsy or direct immunofluorescence attached, and the oral steroid taper plan

ASTHMA • COPD

- ☐ Blood eosinophil count: _____ cells/μL Date: _____ ☐ FeNO: _____ ppb
- ☐ Pulmonary function tests attached. FEV1: _____ %
- ☐ Two or more exacerbations in the previous 12 months, or one requiring hospitalization. Number: _____
- ☐ Dependent on oral corticosteroids. Daily dose: _____
- ☐ Asthma — failed or intolerant to inhaled corticosteroid plus a second controller. Agents: _____
- ☐ COPD — on triple inhaled therapy and still exacerbating. Regimen: _____

NASAL POLYPS • ALLERGIC FUNGAL RHINOSINUSITIS

- ☐ Bilateral nasal polyps confirmed on endoscopy or CT — attach the report
- ☐ Nasal polyp score: _____ / 8 ☐ SNOT-22 score: _____ ☐ Loss of smell
- ☐ Inadequate response to intranasal corticosteroids for at least 8 weeks. Agent: _____
- ☐ Prior sinus surgery — date: _____ ☐ Surgery contraindicated or declined

EOSINOPHILIC ESOPHAGITIS • CHRONIC SPONTANEOUS URTICARIA

- ☐ EoE — endoscopy and biopsy attached. Peak eosinophil count: _____ per high-power field
- ☐ EoE — failed or intolerant to a proton pump inhibitor. Agent and duration: _____
- ☐ Urticaria — symptomatic despite H1 antihistamine, including above-label dosing. Agent: _____
- ☐ Urticaria — UAS7 or UCT score: _____ ☐ Duration of symptoms: _____

ANYTHING ELSE

- ☐ Other medical necessity: _____