| ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER | |
|---|---|
| **ALLERGIES/REACTIONS (REQUIRED):** | Yakima Outpatient Infusion Care<br>808 N 39th Ave Yakima WA 98902<br>Phone: 509-575-1174<br>Fax: 509-577-5021 |
| **ORDERS WITH CHECK BOXES** | When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated. |
| **CODE STATUS** | Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders. |

# DUPILUMAB (DUPIXENT)

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____ Patient Weight: _____ kg Patient Height: _____

**DIAGNOSIS & ICD-10 CODE (REQUIRED):**

- ❑ Asthma, moderate to severe or oral glucocorticoid dependent (ICD-10: _____)
- ❑ Atopic dermatitis (ICD-10: _____)
- ❑ Other: _____ (ICD-10: _____)

**REQUIRED:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
***If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available***

**TREATMENT REGIMEN:** *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

DUPILUMAB SUBCUTANEOUS INJECTION (**ADULT** PATIENTS)

- ❑ INITIAL (ASTHMA/DERMATITIS): 600 mg Sub-Q injection (given as two 300 mg injections) followed by 300 mg every other week
- ❑ MAINTENANCE (ASTHMA/DERMATITIS): 300 mg Sub-Q injection every other week
- ❑ Other (provide dose and frequency): _____

DUPILUMAB SUBCUTANEOUS INJECTION (**PEDIATRIC** PATIENTS)

- ❑ INITIAL: _____ mg Sub-Q injection once, followed by _____ mg every _____ week(s)
- ❑ MAINTENANCE: _____ mg Sub-Q injection every _____ week(s)

**LENGTH OF THERAPY:** ❑ 1 Year (Maximum/Default) ❑ 6 months ❑ Other: _____

**ADDITIONAL INFORMATION/MONITORING:** _____

**SUPPORTIVE CARE:** Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

**DISCHARGE:** 30 minutes after injection when vital signs are stable, and no reaction is present. If no injection-related events with previous 3 doses, may waive post-monitoring period and discharge home after completion.

Provider Signature: _____ Date: _____

Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****

**Patient Identification - Attach Patient Label**

Name:

MRN:

Age / Sex and Gender:

DUPILUMAB (Dupixent)

MultiCare

Yakima Memorial Hospital