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Dupixent Protocol and Consent

1. **Please be aware that you are responsible for your Dupixent refills and medication being at the office you wish to receive your injections in. It is your responsibility to call your pharmacy company for refills when necessary and to notify us if we need to contact the insurance company about refills/approval. Please ask the nurse for list of pharmacies.**
2. Your wait times after each injection will be determined by your physician. If you are receiving Dupixent for asthma, your injections must be given in our office. If you are receiving Dupixent for atopic dermatitis, you may be able to transition to home injections at your physician's discretion.
3. An office visit with physician you see in our practice is required every 3-4 months to evaluate how your injections are going. Your Dupixent injection should be scheduled during our injection hours. However, it should not be scheduled at peak hours in the evening.
4. As with all injections, you cannot be given an injection at the time of illness or fever. Please call the office to reschedule your appointment.

CONSENT FOR ADMINISTRATION OF IMMUNOTHERAPY

Authorization of Treatment

I have read the information in this consent form and in the patient information sheet provided to me and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of Dupixent therapy, and these questions have been answered to my satisfaction. I understand that precautions consistent with the best medical practice will be carried out to protect me from adverse reactions to this therapy. I do hereby give consent for the patient designated below to be given the therapy (Dupixent injections) over an extended period of time and at specified intervals, as prescribed by Princeton Allergy and Asthma. I further hereby give authorization and consent for treatment, from Princeton Allergy and Asthma and the staff, of any reactions that may occur as a result of the injection.
Before receiving Dupixent, please tell Princeton Allergy about all of your medical conditions, including if you:

- Have eye problems.
- Have a parasitic (helminth) infection.
- Are taking oral or inhaled corticosteroid medicines. Do not stop taking your corticosteroid medicines unless instructed by your physician. This may cause other symptoms that were controlled by the corticosteroid medicine to come back.
- Are scheduled to receive any vaccinations.
- If you are pregnant, planning to become pregnant or breast-feeding, Dupixent should not be given.
- Tell your physician about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.
- Do not stop taking your other asthma medicines unless instructed to do so by your physician.

DUPIXENT can cause serious side effects, including:

- Allergy (hypersensitivity) reactions. Serious allergic reactions can happen after you get your Dupixent injection. These include anaphylaxis, angioedema, and rash. Allergic reactions can sometimes happen hours or days after you get a dose of Dupixent. Stop the injections and tell your healthcare provider or get emergency help right away if you have any of the following symptoms of an allergic reaction:
    1. Anaphylaxis
    2. Worsening eye pain or change in vision
    3. Hives
    4. Breathing problems
    5. Rash
    6. Persistent fever
    7. Joint pain or swelling

EYE problems: Tell your healthcare provider if you have any new or worsening eye problems, including eye pain or changes in vision.

- The most common side effects of Dupixent include:
    1. Injection site reaction
    2. Eye lid inflammation, including redness, swelling, itching
    3. Cold sores in mouth or on lips
    4. Throat pain
    5. Insomnia
    6. Tooth pain
    7. Gastritis

Additional side effects may be viewed online.

Please be sure to verify that we have received your medication 2-3 days prior to your Dupixent appointment. If we have not yet received it, please contact your pharmacy.

Please be aware that you will be charged for a Nurse Visit and administration of injection at each visit. You will be responsible for any copays, deductibles and coinsurance

Printed Name of Patient: ________________________________Date: ______________

Patient/Parent Signature: ________________________________Date:_______________

Witness:____Date:________________

FOR OFFICE USE ONLY:

I certify that I have counseled this patient and/or authorized legal guardian concerning the information in this consent for therapy and that it appears to me that the signee understands the nature, risks, and benefits of the proposed treatment plan.

Physician____Date:_______________

2/27/2020