

**Asthma/Respiratory
Enrollment Form**



Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescribing Practitioner:		NPI:	
Address:				Address:			
City:		State/Zip:		City:		State/Zip	
Telephone:		DOB:	M	F	Office:		DEA:
Language Preference:			Wt:	Ht:	Contact:	Phone:	Fax:

PRIMARY INSURANCE INFORMATION								
Member Name:					M	F	DOB:	
Address:					City:			
State:		Zip:		Telephone:		Alt. Telephone:		
Member ID:			Rx Group #:			BIN#:		
PCN#:			Customer Service #:			New	Refill	Ship by:

PLEASE FAX COPY OF: PRESCRIPTION FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

PRESCRIPTION				
Drug	Directions	Quantity	Refills	
Dupixent®	200 mg Pre-filled Syringe	Initial: Inject 400 mg SQ (two 200 mg injections) SQ on day 1 (Quantity: 2) Maintenance: Inject 200 mg SQ every other week starting at day 15 (Quantity: 2)		
	300 mg Pre-filled Syringe	Initial: Inject 600 mg SQ (two 300 mg injections) SQ on day 1 (Quantity: 2) Maintenance: Inject 300 mg SQ every other week starting at day 15 (Quantity: 2)		
		Inject 300 mg SQ every other week (Qty: 2) **Dosing intended for chronic rhinosinusitis with nasal polyposis (CRSwNP)**		
Fasenra®	30mg/mL pre-filled auto injector 30 mg Pre-filled Syringe	Initial: Inject 30 mg SQ once every 4 weeks for first 3 doses Maintenance: Inject 30 mg SQ once every 8 weeks thereafter		
Nucala®	100mg pre-filled auto injector 100mg PFS 100mg Vial* <small>No supplies requested (supplies will be sent with shipment unless indicated)</small>	Patients with Asthma: Inject 100mg subcutaneously once every 4 weeks Patients with EGPA: Inject 300mg (3-100mg injection subcutaneously once every 4 weeks <small>*supplies to be dispensed: One 10mL vial sterile water for injection for every vial of Nucala dispensed, alcohol swabs, 3 mL Luer lock injection syringe, NDL 21G needle for reconstitution, 1mL polypropylene syringe with 21G to 27G x 1.5" needle for subcutaneous injection</small>	28 day supply 28 day supply	
Xolair® Asthma CIU	Prefilled Syringe: 75 mg 150 mg 150 mg single dose vial	Every 4 week dosing: Administer 75 mg dose subcutaneously every 4 weeks Administer 150 mg dose subcutaneously every 4 weeks Administer 300 mg dose subcutaneously every 4 weeks Administer other: _____ mg dose subcutaneously every 4 weeks Every 2 week dosing: Administer 75 mg dose subcutaneously every 2 weeks Administer 150 mg dose subcutaneously every 2 weeks Administer 300 mg dose subcutaneously every 2 weeks Administer other: _____ mg dose subcutaneously every 2 weeks		

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

Previous Therapies: Short acting beta-agonist (SABA): _____ Inhaled corticosteroids with long-acting beta agonist (ICS/LABA) combination therapy: _____ Inhaled corticosteroids (without LABA): _____ Long-acting muscarinic antagonist (LAMA): _____ Leukotriene receptor antagonist (LTRA): _____ Oral/Injectable corticosteroids: _____ Intra-nasal corticosteroids: _____ Topical corticosteroids: _____	Tried & Failed (Duration): _____ _____ _____ _____ _____ _____ _____	Not Tolerated: _____ _____ _____ _____ _____ _____ _____	Contraindication: _____ _____ _____ _____ _____ _____ _____
---	--	---	---

D86.9 Sarcoidosis, unspecified J45.40 Moderate Persistent Asthma, uncomplicated J45.51 Severe Persistent Asthma w/ acute exacerbation L50.1 Chronic Idiopathic Urticaria Date of Diagnosis: ____/____/____ Allergies: _____	J33.0 Polyp of Nasal Cavity J45.41 Moderate Persistent Asthma w/ acute exacerbation Other: _____ Patient Weight: _____	IgE Level _____ Date: ____/____/____ Eosinophil levels: _____ cells/mcL Date: ____/____/____ Patient has had prior sinus surgery Number of severe exacerbations past 12 months: _____ Patient has moderate to severe asthma that requires add-on maintenance treatment Patient is not a candidate for surgery Rationale: _____
--	--	---

Injection Training: Patient has received pen and injection training Physician's office to provide injection training FOSRX/FAST to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: _____	Date: _____
--	--------------------