

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: Patient MD Office Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____	ID: _____	Group: _____
Secondary Insurance: _____	ID: _____	Group: _____
Prescription Card: _____	ID: _____	BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

<input type="checkbox"/> J45.909 Asthma, Unspecified <input type="checkbox"/> L20.9 Atopic Dermatitis <input type="checkbox"/> L50.1 Chronic Idiopathic Urticaria <input type="checkbox"/> J45.40 Moderate Persistent Asthma, Uncomplicated <input type="checkbox"/> J45.41 Moderate Persistent Asthma w/ Acute Exacerbation <input type="checkbox"/> J33.0 Polyp of Nasal Cavity <input type="checkbox"/> D86.9 Sarcoidosis, Unspecified <input type="checkbox"/> Other: _____	Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Height: _____ <input type="checkbox"/> cm <input type="checkbox"/> in %BSA: _____ Allergies: _____ <input type="checkbox"/> NKDA Injection Training/Home Health RN visit is necessary: <input type="checkbox"/> Yes <input type="checkbox"/> No Site of Care: <input type="checkbox"/> Home <input type="checkbox"/> MD Office <input type="checkbox"/> Other: _____ Eosinophil count: _____ cells per uL IgE Levels: _____ Date of Test: _____ Number of exacerbations in the last 12 months: _____ <input type="checkbox"/> Patient is not a candidate for surgery Rationale: _____
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PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills
Dupixent® (dupilumab)	<input type="checkbox"/> 200 mg per 1.14 mL prefilled syringe 2 pack	<input type="checkbox"/> Starter Dose: Administer two syringes (total of 400 mg) SUBQ on Day 1 then one syringe (200 mg) every two weeks starting on Day 15 thereafter <input type="checkbox"/> Maintenance Dose: Administer 200mg SUBQ every two weeks	<input type="checkbox"/> 2	
	<input type="checkbox"/> 300 mg per 2 mL prefilled syringe 2 pack	<input type="checkbox"/> Starter Dose: Administer two syringes (total of 600 mg) SUBQ on Day 1 then one syringe (300 mg) every two weeks starting on Day 15 thereafter <input type="checkbox"/> Maintenance Dose: Administer 300mg SUBQ every two weeks	<input type="checkbox"/> 2	
	<input type="checkbox"/> 300mg Prefilled Pen	<input type="checkbox"/> Inject 300 mg SUBQ every other week **Dosing intended for chronic rhinosinusitis with nasal polyposis (CRSwNP)**		
Fasenra™ (benralizumab)	<input type="checkbox"/> 30mg PFS <input type="checkbox"/> 30mg Autoinjector	<input type="checkbox"/> Starter Dose: Administer 30mg SUBQ every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Administer 30mg SUBQ every 8 weeks		
Nucala® (mepolizumab)	<input type="checkbox"/> 100mg vial <input type="checkbox"/> 100mg PFS <input type="checkbox"/> 100mg Autoinjector	<input type="checkbox"/> Inject 100mg SUBQ once every 4 weeks into the upper arm, thigh, or abdomen <input type="checkbox"/> Supplies: • 1 sterile water for injection (10ml) for every vial of Nucala dispensed • 1-ml polypropylene syringe with 21-to 27-G x 0.5-inch needle for SUBQ injection • Alcohol swabs • 3 mL Luer Lock injection syringe • ND 21G needle for reconstitution Send quantity sufficient for medication days supply <input type="checkbox"/> No supplies (The above supplies will be sent with shipment unless indicated)	<input type="checkbox"/> 28 days	
Xolair® (Omalizumab) <input type="checkbox"/> Asthma <input type="checkbox"/> CSU	<input type="checkbox"/> 75mg PFS <input type="checkbox"/> 150mg PFS <input type="checkbox"/> 150 mg single dose vial	Every 4 week dosing: <input type="checkbox"/> Administer 75 mg dose SUBQ every 4 weeks <input type="checkbox"/> Administer 150 mg dose SUBQ every 4 weeks <input type="checkbox"/> Administer 300 mg dose SUBQ every 4 weeks <input type="checkbox"/> Other: Administer _____ mg per dose SUBQ every 4 weeks		
		Every 2 week dosing: <input type="checkbox"/> Administer 75 mg dose SUBQ every 2 weeks <input type="checkbox"/> Administer 150 mg dose SUBQ every 2 weeks <input type="checkbox"/> Administer 300 mg dose SUBQ every 2 weeks <input type="checkbox"/> Other: Administer _____ mg per dose SUBQ every 2 weeks		
		<input type="checkbox"/> Supplies: • 1 vial sterile water for injection (10 mL vial) for every vial of Xolair dispensed • ND 25G x 5/8" Safety Glide needle for SUBQ injection • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL Luer Lock injection syringe • ND 18G x 1 & 1/2" Safety Glide needle for reconstitution Send quantity sufficient for medication days supply <input type="checkbox"/> No supplies (The above supplies will be sent with shipment unless indicated)		

Prescriber Signature: _____ **Date:** _____

