InfuCare Rx®

Asthma/Allergy Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

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

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

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
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

☐ J45.909 Asthma, Unspecified
☐ L20.9 Atopic Dermatitis
☐ L50.1 Chronic Idiopathic Urticaria
☐ K20.0 Eosinophilic Esophagitis
☐ J45.40 Moderate Persistent Asthma, Uncomplicated
☐ J45.41 Moderate Persistent Asthma w/ Acute Exacerbation
☐ J33.0 Polyp of Nasal Cavity
☐ D86.9 Sarcoidosis, Unspecified
☐ Other: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
Injection Training/Home Health RN visit is necessary: ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other: _____
Eosinophil count: _____ cells per uL IgE Levels: _____ Date of Test: _____
Number of exacerbations in the last 12 months: _____
☐ Patient is not a candidate for surgery Rationale: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills
☐ Dupixent® (dupilumab)	☐ 200mg per 1.14mL PFS 2 pack ☐ 200mg Prefilled Pen	☐ **Starter Dose:** Administer two syringes (total of 400mg) SUBQ on Day 1 then one syringe (200mg) every two weeks starting on Day 15 thereafter ☐ **Maintenance Dose:** Administer 200mg SUBQ every two weeks	☐ 2	
	☐ 300mg per 2 mL PFS 2 pack ☐ 300mg Prefilled Pen	☐ **Starter Dose:** Administer two syringes (total of 600mg) SUBQ on Day 1 then one syringe (300mg) every two weeks starting on Day 15 thereafter ☐ **Maintenance Dose:** Administer 300mg SUBQ every two weeks	☐ 2	
		☐ Inject 300mg SUBQ every other week **Dosing intended for chronic rhinosinusitis with nasal polyposis (CRSwNP)**		
		☐ Inject 300mg SUBQ every week **Dosing intended for eosinophilic esophagitis**	☐ 4	
☐ Fasenra™ (benralizumab)	☐ 30mg PFS ☐ 30mg Autoinjector	☐ **Starter Dose:** Administer 30mg SUBQ every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter ☐ **Maintenance Dose:** Administer 30mg SUBQ every 8 weeks		
☐ Nucala® (mepolizumab)	☐ 100mg vial ☐ 100mg PFS ☐ 100mg Autoinjector	☐ Inject 100mg SUBQ once every 4 weeks into the upper arm, thigh, or abdomen ☐ **Supplies:** • 1 sterile water for injection (10ml) for every vial of Nucala dispensed • 1-ml polyprophylene syringe with 21-to 27-G x 0.5-inch needle for SUBQ injection • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution Send quantity sufficient for medication days supply ☐ No supplies (The above supplies will be sent with shipment unless indicated)	☐ 28 days	
☐ Xolair® (Omalizumab) ☐ Asthma ☐ CSU	☐ 75mg PFS ☐ 150mg PFS ☐ 150mg single dose vial	Every 4 week dosing: ☐ Administer 75mg dose SUBQ every 4 weeks ☐ Administer 150mg dose SUBQ every 4 weeks ☐ Administer 300mg dose SUBQ every 4 weeks ☐ Other: Administer _____ mg per dose SUBQ every 4 weeks Every 2 week dosing: ☐ Administer 75mg dose SUBQ every 2 weeks ☐ Administer 150mg dose SUBQ every 2 weeks ☐ Administer 300mg dose SUBQ every 2 weeks ☐ Other: Administer _____ mg per dose SUBQ every 2 weeks ☐ **Supplies:** • 1 vial sterile water for injection (10mL vial) for every vial of Xolair dispensed • NDL 25G x 5/8" Safety Glide needle for SUBQ injection • Alcohol swabs • Flexible bandages 1" x 3" • 3mL Luer Lock injection syringe • NDL 18G x 1 & ½" Safety Glide needle for reconstitution Send quantity sufficient for medication days supply ☐ No supplies (The above supplies will be sent with shipment unless indicated)		

Prescriber Signature: _____ **Date:** _____

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