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 INF ORMATION	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

- 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 1.14 mL 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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