

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).



Asthma

Prescription/Pharmacy Intake Form

Central Pharmacy: _____
 Retail/Community Pharmacy Fax: _____ Pharmacy Phone: _____
Date Needed: _____ **Ship To:** Prescriber's Office Patient's Home Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ Male Female
Address: _____
City: _____ State: _____ Zip code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____ Case Manager: _____

Insurance provider (Please include copy of front and back of card): _____
ID #: _____ Policy/Group #: _____ Phone #: _____ Patient is eligible for Medicare
Name of Insured: _____ Employer: _____
Relationship to Patient: Self Other: _____ Prescription Card: Yes No Carrier: _____ Policy/Group #: _____
Will there be access to anaphylactic medications and oxygen at the administration site? _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

Patient is new to therapy Patient is restarting therapy Patient is currently on therapy Start date: _____
Diagnosis: Moderate persistent asthma, uncomplicated (J45.40) Severe persistent asthma, uncomplicated (J45.50) Eosinophilic granulomatosis with polyangiitis (M30.1)
 Pulmonary eosinophilia, not elsewhere classified (J82) Other _____ Date of Diagnosis: _____
Other Diagnosis/Conditions: _____
Eosinophil count _____ Cells/ μ L IgE Level _____ IU/mL Current Weight: _____ lb kg Date: _____ Current Height: _____ in cm Date: _____
 Other Therapies Tried & Failed (Please List): _____
Allergies: _____

PRESCRIPTION INFORMATION

<p><input type="checkbox"/> Cinqair (reslizumab) 100 mg/10 mL vial Directions: 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes. To be administered by a healthcare professional. Quantity: _____ Refills: _____</p> <p><input type="checkbox"/> Dupixent (dupilumab) <input type="checkbox"/> 200 mg/1.14 mL pre-filled syringe Initial dose of 400 mg (two 200 mg injections at different injection sites) followed by 200 mg given every other week into the thigh or abdomen by subcutaneous injection. <input type="checkbox"/> 300 mg/2 mL pre-filled syringe Initial dose of 600 mg (two 300 mg injections at different injection sites) followed by 300 mg given every other week into the thigh or abdomen by subcutaneous injection. Quantity: _____ Refills: _____</p> <p><input type="checkbox"/> Fasenra (benralizumab) 30 mg/mL pre-filled syringe Directions: 30 mg/mL into the upper arm, thigh or abdomen by subcutaneous injection every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter. To be administered by a healthcare professional. Quantity: _____ Refills: _____</p> <p><input type="checkbox"/> Fasenra (benralizumab) Pen Directions: 30mg administered once every 4 weeks for the first 3 doses, then once every 8 weeks thereafter by subcutaneous injection into the upper arm, thigh or abdomen. Quantity: _____ Refills: _____</p>	<p><input type="checkbox"/> Nucala (mepolizumab) 100 mg vial Directions: SEVERE ASTHMA <input type="checkbox"/> 100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen. To be administered by a healthcare professional. EOSINOPHILIC GRANULOMATOSIS WITH POLYAGNIITIS (EGPA) <input type="checkbox"/> 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh or abdomen. To be administered by a healthcare professional. Quantity: _____ Refills: _____</p> <p><input type="checkbox"/> Xolair (omalizumab) 150 mg vial kit <input type="checkbox"/> Supply Kit (#2) 18g 1 & 1/2 syringe 3ml (#2) 25g 5/8 safety needle (#2) alcohol swabs</p> <p><input type="checkbox"/> Xolair PFS (omalizumab) 75 mg/0.5 mL pre-filled syringe <input type="checkbox"/> Xolair PFS (omalizumab) 150 mg/1 mL pre-filled syringe Directions: Every 4 weeks dosing: <input type="checkbox"/> 75 mg per dose subcutaneously every 4 weeks. To be administered by a healthcare professional. <input type="checkbox"/> 150 mg per dose subcutaneously every 4 weeks. To be administered by a healthcare professional. <input type="checkbox"/> 225 mg per dose subcutaneously every 4 weeks. To be administered by a healthcare professional. <input type="checkbox"/> 300 mg per dose subcutaneously every 4 weeks. To be administered by a healthcare professional. Every 2 weeks dosing: <input type="checkbox"/> 225 mg per dose subcutaneously every 2 weeks. To be administered by a healthcare professional. <input type="checkbox"/> 300 mg per dose subcutaneously every 2 weeks. To be administered by a healthcare professional. <input type="checkbox"/> 375 mg per dose subcutaneously every 2 weeks. To be administered by a healthcare professional. Quantity: _____ Refills: _____</p> <p><input type="checkbox"/> Other: _____ Directions: _____ Quantity: _____ Refills: _____</p>
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I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____
Address: _____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax: _____
Email: _____ Best time to call: _____ Preferred method of contact: Email Phone Fax
State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date