

ASTHMA & ALLERGY REFERRAL FORM (A-D)

PHONE 888.370.1724 | FAX 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION					
Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email		Home Phone	Work Phone	Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)			Alt Contact Email	Alt Contact Phone	

PRESCRIBER INFORMATION					
Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone	Office Fax		
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes					
Patient New to Therapy <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment <input type="checkbox"/>					Therapy Start Date
Therapies Tried and Failed (please list medications)					
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Patient has had Chronic Idiopathic Urticaria for 6 weeks or more <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other/Concomitant Medications (please list)		<input type="checkbox"/> History of positive skin or RAST test to a perennial aeroallergen			
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)		<input type="checkbox"/> Other Allergies (please list)			
Pretreatment serum IgE level _____ IU/mL	Test date _____	Eosinophil levels (if available) _____ cells/mcL		Test date _____	
Pretreatment FEV1 (if available) _____ %	Date obtained _____	Number of severe exacerbations in the past 12 months _____			
Initial Treatment - Classification of asthma as uncontrolled or inadequately controlled as defined by: <input type="checkbox"/> Poor symptom control <input type="checkbox"/> Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months <input type="checkbox"/> Asthma-related emergency treatment <input type="checkbox"/> Airflow limitation <input type="checkbox"/> Currently dependent on oral corticosteroids for treatment of asthma					
Ongoing Treatment - Positive response to treatment demonstrated by: <input type="checkbox"/> Reduction in frequency and/or severity of relapses <input type="checkbox"/> Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant <input type="checkbox"/> Disease remission <input type="checkbox"/> Reduction in severity or frequency of EGPA-related symptoms					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
ICD-10 Code <input type="checkbox"/> Code _____ Description _____					

PRESCRIPTION INFORMATION - Please Escribe if required by state law
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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Cinqair <i>Asthma, severe eosinophilic</i>	<input type="checkbox"/> 100 mg/mL Vial	<input type="checkbox"/> Infuse _____ mg (3 mg/kg x _____ kg) IV once every 4 weeks	28 Day	_____
<input type="checkbox"/> Dupixent <i>Moderate-to-severe asthma</i>	Patients aged >12 years <input type="checkbox"/> 200 mg/1.14 mL PFS <input type="checkbox"/> 200 mg/1.14 mL PEN	<input type="checkbox"/> Initial Dose: Inject 400 mg (2x200 mg) injections SubQ on Day 1 and 200 mg SubQ on Day 15 <input type="checkbox"/> Maintenance Dose: Inject 200 mg SubQ every 2 weeks	3 2	0 _____
	Patients aged >12 years <input type="checkbox"/> 300 mg/2 mL PFS <input type="checkbox"/> 300 mg/2 mL PEN	<input type="checkbox"/> Initial Dose: inject 600 mg (2x300 mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15 <input type="checkbox"/> Maintenance Dose: Inject 300 mg SubQ every 2 weeks	3 2	0 _____
	Patients aged 6-11 years (Weight: _____ kg (1 kg = 2.2 lb)) Weight 15 kg to <30 kg <input type="checkbox"/> 100 mg/0.67 mL PFS <input type="checkbox"/> 300 mg/2 mL PFS	<input type="checkbox"/> Inject 100 mg SubQ every 2 weeks <input type="checkbox"/> Inject 300 mg SubQ every 4 weeks	2 1	_____
	Patients aged 6-11 years (Weight: _____ kg (1 kg = 2.2 lb)) Weight >30 kg <input type="checkbox"/> 200 mg/1.14 mL PFS	<input type="checkbox"/> Inject 200 mg SubQ every 2 weeks	2	_____

_____ Prescriber Signature	_____ Date	_____ Supervising Physician Signature (where required by state law)	_____ Date
_____ DAW (Dispense as Written)	_____ Date	_____ Brand Necessary (must handwrite)	

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ASTHMA & ALLERGY REFERRAL FORM (D)

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address		City	State		ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)			Alt Contact Email		Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Referral Contact Email	Office Phone	Office Fax			
Practice / Facility Name	Prescriber Name / Specialty				
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment <input type="checkbox"/>	Therapy Start Date
Therapies Tried and Failed (please list medications)	
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty: _____	Date Provided: _____
Patient Height (cm/in): _____	Weight (kg/lbs): _____
Date Obtained: _____	
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has had Chronic Idiopathic Urticaria for 6 weeks or more <input type="checkbox"/> Yes <input type="checkbox"/> No
Other/Concomitant Medications (please list)	<input type="checkbox"/> History of positive skin or RAST test to a perennial aeroallergen
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)	<input type="checkbox"/> Other Allergies (please list)
Pretreatment serum IgE level _____ IU/mL	Test date _____
Pretreatment FEV1 (if available) _____%	Date obtained _____
Eosinophil levels (if available) _____ cells/mcL	Test date _____
Number of severe exacerbations in the past 12 months _____	
Initial Treatment - Classification of asthma as uncontrolled or inadequately controlled as defined by:	
<input type="checkbox"/> Poor symptom control <input type="checkbox"/> Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months	
<input type="checkbox"/> Asthma-related emergency treatment <input type="checkbox"/> Airflow limitation <input type="checkbox"/> Currently dependent on oral corticosteroids for treatment of asthma	
Ongoing Treatment - Positive response to treatment demonstrated by:	
<input type="checkbox"/> Reduction in frequency and/or severity of relapses <input type="checkbox"/> Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant	
<input type="checkbox"/> Disease remission <input type="checkbox"/> Reduction in severity or frequency of EGPA-related symptoms	
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)	
ICD-10 Code <input type="checkbox"/> Code _____	Description _____

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Dupixent Oral CS-dependent asthma or co-morbid AD or adults with co-morbid rhinosinusitis w/nasal polyps	Patients aged >12 years <input type="checkbox"/> 300 mg/2 mL PFS <input type="checkbox"/> 300 mg/2 mL PEN	<input type="checkbox"/> Initial Dose: Inject 600 mg (2x300 mg) injections on Day 1 and 300 mg SubQ on Day 15 <input type="checkbox"/> Maintenance Dose: Inject 300 mg SubQ every 2 weeks	3	0
	Patients aged 6-11 years (Weight: _____ kg (1 kg = 2.2 lb)) <input type="checkbox"/> 300 mg/2 mL PFS	<input type="checkbox"/> Initial Dose: Inject 600 mg (2x300mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15 <input type="checkbox"/> Maintenance Dose: Inject 300 mg SubQ every 4 weeks	3	0
	Weight 30 kg to <60 kg <input type="checkbox"/> 200 mg/1.14 mL PFS	<input type="checkbox"/> Initial Dose: Inject 400 mg (2x200mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15 <input type="checkbox"/> Maintenance Dose: Inject 200 mg SubQ every 2 weeks	3	0
	Weight >60 kg <input type="checkbox"/> 300 mg/2 mL PFS	<input type="checkbox"/> Initial Dose: Inject 600 mg (2x300mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15 <input type="checkbox"/> Maintenance Dose: Inject 300 mg SubQ every 2 weeks	3	0
<input type="checkbox"/> Dupixent Chronic rhinosinusitis w/nasal polyposis	<input type="checkbox"/> 300 mg/2 mL PFS <input type="checkbox"/> 300 mg/2 mL PEN	<input type="checkbox"/> Inject 300 mg SubQ every 2 weeks	2	0
<input type="checkbox"/> Fasenra Asthma, severe eosinophilic	<input type="checkbox"/> 30 mg/mL PFS	<input type="checkbox"/> Office-Administered Loading Dose: Inject 30 mg SubQ once every 4 weeks for 3 doses	3	0
	<input type="checkbox"/> 30 mg/mL PEN	<input type="checkbox"/> Self-Administered Maintenance Dose: Inject 30 mg SubQ once every 8 weeks	1	0

Prescriber Signature _____

Date _____

Supervising Physician Signature (where required by state law) _____

Date _____

DAW (Dispense as Written) _____

Date _____

Brand Necessary (must *handwrite*) _____

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Address		City	State	ZIP	
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
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Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone	Office Fax		
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

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CLINICAL INFORMATION - Please include applicable clinical chart notes					
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Therapies Tried and Failed (please list medications)					
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Patient has had Chronic Idiopathic Urticaria for 6 weeks or more <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other/Concomitant Medications (please list)		<input type="checkbox"/> History of positive skin or RAST test to a perennial aeroallergen			
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)		<input type="checkbox"/> Other Allergies (please list)			
Pretreatment serum IgE level _____ IU/mL	Test date _____	Eosinophil levels (if available) _____ cells/mcL		Test date _____	
Pretreatment FEV1 (if available) _____%	Date obtained _____	Number of severe exacerbations in the past 12 months _____			
Initial Treatment - Classification of asthma as uncontrolled or inadequately controlled as defined by: <input type="checkbox"/> Poor symptom control <input type="checkbox"/> Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months <input type="checkbox"/> Asthma-related emergency treatment <input type="checkbox"/> Airflow limitation <input type="checkbox"/> Currently dependent on oral corticosteroids for treatment of asthma					
Ongoing Treatment - Positive response to treatment demonstrated by: <input type="checkbox"/> Reduction in frequency and/or severity of relapses <input type="checkbox"/> Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant <input type="checkbox"/> Disease remission <input type="checkbox"/> Reduction in severity or frequency of EGPA-related symptoms					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
ICD-10 Code <input type="checkbox"/> Code _____ Description _____					

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Nucala	<input type="checkbox"/> 100 mg Vial (Office Administered Only) <input type="checkbox"/> 100 mg/mL Auto-Injector <input type="checkbox"/> 100 mg/mL PFS	<input type="checkbox"/> Pediatric Severe Asthma (6-11 years of age): 40 mg SubQ to upper arm, thigh or abdomen once every 4 weeks (VIAL for Office Administration Only) <input type="checkbox"/> Severe Asthma in Patients 12 years and older / CRSwNP in Patients 18 years and older: 100 mg SubQ to upper arm, thigh or abdomen once every 4 weeks <input type="checkbox"/> Adult EGPA / HES in Patients 12 years and older: Inject 300 mg SubQ administered as 3 separate 100 mg injections to upper arm, thigh or abdomen once every 4 weeks	28-Day 28-Day 28-Day	_____ _____ _____
<input type="checkbox"/> Tezspire	<input type="checkbox"/> 210 mg/1.91 mL (110 mg/mL) PFS	<input type="checkbox"/> Inject 210 mg SubQ once every 4 weeks. Note: Office/HCP Administered Product	1	_____
<input type="checkbox"/> Xolair To be administered: <input type="checkbox"/> By a healthcare professional <input type="checkbox"/> In the Home If administered in the home, has patient received at least 3 doses of Xolair, under HCP guidance, with no hypersensitivity reactions? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Asthma (dose is dependent on weight and IgE levels, see package insert: 75 to 375 mg every 2 or 4 weeks) <input type="checkbox"/> CIU (fixed dose, not dependent on weight or IgE levels: 150 or 300 mg every 4 weeks) <input type="checkbox"/> Nasal Polyposis (75 to 600 mg every 2 or 4 weeks)	<input type="checkbox"/> Prefilled Syringe Pharmacy to dispense the least amount of 75 mg or 150 mg Syringes to complete total dose. PFS available in 75 mg and 150 mg strengths. <input type="checkbox"/> 150 mg Single Dose VIAL	<input type="checkbox"/> Every 4 weeks dosing: Administer: <input type="checkbox"/> 75 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 225 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 450 mg <input type="checkbox"/> 600 mg <input type="checkbox"/> Every 2 weeks dosing: Administer: <input type="checkbox"/> 225 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 375 mg <input type="checkbox"/> 450 mg <input type="checkbox"/> 525 mg <input type="checkbox"/> 600 mg	28 Day	_____
<input type="checkbox"/> Epinephrine <input type="checkbox"/> EpiPen	<input type="checkbox"/> 0.3 mg <input type="checkbox"/> 0.15 mg	<input type="checkbox"/> Inject IM as needed for anaphylaxis <input type="checkbox"/> Other: _____		_____

_____ Prescriber Signature	_____ Date	_____ Supervising Physician Signature (where required by state law)	_____ Date
_____ DAW (Dispense as Written)	_____ Date	_____ Brand Necessary (must <i>handwrite</i>)	

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