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	١								,					
Last Name	First Nan	ne	DC	ОВ		Gender	□М	□F	Last 4 SSN		F	Primary Lang	uage	
Address					City					Sta	:e	z	ZIP	
Email	il Home Phone					Wo	Work Phone					Cell Phone	е	
Primary Contact Method (chec	ck one) 🗆 Cell Ph	one 🗆 Home	Phone	☐ Work Phone	e 🗆 Te	ext 🗆 E	mail	□ Pri	imary Caregive	er 🗆 🛭	O NOT	CONTACT		
Primary Caregiver/Alt Contact	Name (If applicabl	e)		Alt Conta	ct Emai	I					A	Alt Contact P	hone	
PRESCRIBER INFORMA	TION													
Name of Contact Sending Refe	erral			Title				Prefe	erred Contact	Method	check or	ne) 🗆 Emai	I □ Phone	□ Fax
Referral Contact Email				Office Phone Office Fax										
Practice / Facility Name						Prescri	ber Na	me / 9	Specialty					
Address	C	ity		State	ZIF	•								
Prescriber State License #		١	NPI#					Medica	aid UPIN #					
	* /	Please inclu	ıde a	copy of the	e froi	nt and	back	of	insurance	card				
CLINICAL INFORMATIO	N - Please inc	lude applica	ble cli	nical chart n	otes									
Patient New to Therapy 🗆 Naïv	ve/New Start 🗆 🗆	Therapy Restart	□ Exis	sting Treatment						Therapy	Start Dat	te		
Therapies Tried and Failed (ple	ease list medication	ns)												
Sample/Starter Provided? ☐ N	lo □ Yes, Provide C	Qty: Da	ate Prov	ided:	Р	atient He	ight (cr	n/in):	: Wei	ght (kg/	bs):	Date 0	Obtained:	
If Self-injectable drug, is inject	ion training coordi	nation required	by our p	harmacy? 🗆 Yes	. □ No		Patier	nt has	had Chronic I	diopathi	Urticari	a for 6 weeks	s or more \square Y	es □ No
Other/Concomitant Medication	ns (please list)					History	of posit	ive sk	in or RAST tes	st to a pe	rennial a	eroallergen		
Allergies □ NKDA □ Drug A	Allergies (please lis	st)				Other A	lergies	(plea	se list)					
Pretreatment serum IgE level _		Test date							ailable)			Test date _		
Pretreatment FEV1 (if available		Test date Date obtai					severe	exac	erbations in th	ne past 12	months			
Initial Treatment - Classificatio ☐ Poor symptom control ☐ Asthma-related emergency t	Two or more bursts	s of systemic cor	ticoster	oids for at least	3 days	each in th				thma				
Ongoing Treatment - Positive III Reduction in frequency and/	or severity of relap	ses 🗆 Reduct	ion or d		of doses	of cortic	osteroio	ds and	d/or immunosi	uppressa	nt			
Ship to Address ☐ Home ☐	☐ Prescriber's Offic	e 🗆 Other (ple	ease list))										
ICD-10 Code	Description _													
PRESCRIPTION INFORM	MATION - Plea	se Escribe if	requi	red by state	law									
In order for a brand name p														
or your state-specific requirements MEDICATION	DOSE	prombit substi		CTIONS	ioi a v	aliu pres	criptic	וווונ	illi i Or Wiltin	g contr	Jileu IIIe	edications.	QTY	REFILLS
		-1			/7 mag	Tem se	lem's	11/		alia			QIY	REFILLS
☐ Cinqair Asthma, severe eosinphilic	□ 100 mg/mL Via			use mg						eks			28 Day	
☐ Dupixent Moderate-to-severe asthma	Patients aged >1: ☐ 200 mg/1.14 m			tial Dose: Inject 4 bQ on Day 1 and					ns				3	О
	□ 200 mg/1.14 m			intenance Dose:		_	-		weeks				2	
	Patients aged >1	2 vears			-	mg (2x300 mg) injections								
	□ 300 mg/2 mL PFS □ 300 mg/2 mL PEN					mg SubQ on Day 15							3	0
			☐ Maintenance Dose: Inje			ct 300 mg SubQ every 2 weeks							2	
	Patients aged 6-1 (Weight:			ect 100 mg Sub(Q every	2 weeks							2	
	Weight 15 kg to	<30 kg		ect 300 mg Sub	Q everv	4 weeks								
	□ 300 mg/2 mL												1	
Patients aged 6-11 years (Weight:kg (1 kg = 2.2 lb) Weight > 30 kg □ 200 mg/1.14 mL PFS							2 weeks						2	
Prescriber Signature	1		Date		-				Signature (wh	ere requ	ired by st	tate law)	Date	
DAW (Dispense as Written)			Date		ı	brand Ne	cessary	(mus	t handwrite)					

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

ASTHMA & ALLERGY REFERRAL FORM (D)

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PATIENT INFORMATION	1									
Last Name	First Name	DOB		Gender 🗆 M	□F	Last 4 SSN		Primary Lang	guage	
Address			City				State	;	ZIP	
Email	Home Phone	•		Work Ph	one			Cell Phon	е	
Primary Contact Method (chec	ck one) Cell Phone Home	e Phone	ne 🗆 Te	xt 🗆 Email	□ Pr	imary Caregiver	□ DO N	NOT CONTACT		
Primary Caregiver/Alt Contact	Name (If applicable)	Alt Cont	act Email					Alt Contact F	Phone	
PRESCRIBER INFORMA	TION									
Name of Contact Sending Refe	erral	Title			Pref	erred Contact Me	thod (che	ck one) 🗆 Emai	il 🗆 Phone	□ Fax
Referral Contact Email				Office Phone	•			Office Fax		
Practice / Facility Name				Prescriber N	ame /	Specialty				
Address				ity	ZII	P				
Prescriber State License #	DEA #			PI#		-		edicaid UPIN #		
	* Please inc	lude a copy of th	ne fron	t and bac	k of	insurance c	ard *			
CLINICAL INFORMATIO	N - Please include applic	able clinical chart	notes							
Patient New to Therapy 🗆 Naï	ve/New Start	t 🗆 Existing Treatmen	t			Th	erapy Sta	rt Date		
Therapies Tried and Failed (ple	ease list medications)									
Sample/Starter Provided? □ N	o ☐ Yes, Provide Qty:	Date Provided:	Pa	atient Height (cm/in)	: Weigh	t (kg/lbs):	Date (Obtained:	
If Self-injectable drug, is inject	ion training coordination required	by our pharmacy?	es 🗆 No	Pati	ent has	s had Chronic Idio	pathic Ur	ticaria for 6 week	s or more	Yes □ No
Other/Concomitant Medication	ns (please list)			History of pos	itive s	kin or RAST test t	o a pereni	nial aeroallergen		
Allergies □ NKDA □ Drug	Allergies (please list)			Other Allergie	s (plea	ase list)				
Pretreatment serum IgE level _ Pretreatment FEV1 (if available	IU/mL Test date Date obt	ained		osinophil level: umber of seve		ailable) cerbations in the p		/mcL Test date _ onths		
☐ Poor symptom control ☐	n of asthma as uncontrolled or in Two or more bursts of systemic or creatment	orticosteroids for at leas	t 3 days e	ach in the pre			na			
☐ Reduction in frequency and/	response to treatment demonstra for severity of relapses	ction or discontinuation		of corticostero	oids an	d/or immunosupp	oressant			
	☐ Prescriber's Office ☐ Other (p									
ICD-10 Code		,								
	MATION - Please Escribe	if required by state	e law							
In order for a brand name p	product to be dispensed, the p	orescriber must hand	lwrite "B							
	red language to prohibit subs		not a ve	alia prescript	1011 10	rm for writing t	controlle	a medications.	OTV.	DEFILLS
MEDICATION	DOSE	DIRECTIONS							QTY	REFILLS
☐ Dupixent Oral CS-dependent	Patients aged >12 years ☐ 300 mg/2 mL PFS	☐ Initial Dose: Injec	_		-	-	00 mg Su	bQ on Day 15	3	0
asthma or co-morbid AD or adults with co-morbid	□ 300 mg/2 mL PEN	☐ Maintenance Dos							2	
rhinosinusitis w/nasal polyps	Patients aged 6-11 years (Weight: kg (1 kg = 2.2 lb			mg (2x300mg) injections) mg SubQ on Day 15					3	0
	□ 300 mg/2 mL PFS	☐ Maintenance Dos	e: Inject 3	00 mg SubQ e	very 4	weeks			1	
	Weight 30 kg to <60 kg	☐ Initial Dose: Injec	t 400 mg	(2x200mg) in	jectior	ıs			3	0
	☐ 200 mg/1.14 mL PFS	SubQ on Day 1 ar	nd 300 mg	omg SubQ on Day 15 ct 200 mg SubQ every 2 weeks mg (2x300mg) injections omg SubQ on Day 15					3	
		☐ Maintenance Dos	e: Inject 2						2	
	Weight >60 kg ☐ 300 mg/2 mL PFS								3	0
		☐ Maintenance Dos	e: Inject 3	00 mg SubQ e	every 2	weeks			2	
☐ Dupixent Chronic rhinosinusitis w/nasal polyposis	☐ 300 mg/2 mL PFS ☐ 300 mg/2 mL PEN	□ Inject 300 mg Su	bQ every	2 weeks					2	
☐ Fasenra	☐ 30 mg/mL PFS	☐ Office-Administer	red Loadii	ng Dose: Inject	30 m	g SubQ once ever	y 4 weeks	for 3 doses	3	0
Asthma, severe eosinphilic	□ 30 mg/mL PEN	☐ Self-Administered	d Mainten	ance Dose: Inje	ect 30	mg SubQ once ev	ery 8 wee	ks	1	
rescriber Signature		Date	 Si	upervising Phy	sician	Signature (where	required		Date	
			_	rand Necessar						
AW (Dispense as Written)		Date	В	iana necessar	y (inus	t nanuwrite)				

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ASTHMA & ALLERGY REFERRAL FORM (E-Z)

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PATIENT INFORMATION	١												
Last Name	First N	First Name DOB		В	Gender □ M □ F			Last 4 SSN	Prin	Primary Language			
Address					City			State			ZIP		
Email	Home Phone					Work Phone					Cell Phone		
Primary Contact Method (chec	ck one) 🗆 Cell	Phone	Phone	☐ Work Phone	e 🗆 Tex	t 🗆 Email	□ Pr	imary Caregive	er 🗆 DO	NOT CON	NTACT		
Primary Caregiver/Alt Contact Name (If applicable) Alt Contact Email Alt Contact Email													
PRESCRIBER INFORMA	TION												
Name of Contact Sending Refe	rral			Title			Pref	erred Contact	Method (ch	neck one)	☐ Email	☐ Phone	□ Fax
Referral Contact Email					Office Phone Office Fax								
Practice / Facility Name Prescriber Name / Specialty													
Address		Ci			ity					ZIP			
Prescriber State License #		DEA #				· ·I #	-			Medicaid UPIN #			
* Please include a copy of the front and back of insurance card *													
CLINICAL INFORMATIO						. dirid iba			ou. u				
CLINICAL INFORMATION - Please include applicable clinical chart notes													
Patient New to Therapy													
Therapies Tried and Failed (ple			hata De'	dod		tiont Halada	(ans /! `		abt dec /0	٠١,	D-4- C'	ataine d	
Sample/Starter Provided?	· · · · · · · · · · · · · · · · · · ·		ate Provi			tient Height			ght (kg/lbs			otained:	
If Self-injectable drug, is injecti		aination required	by our ph	ıarmacy? ∐ Yes				had Chronic I	<u> </u>			or more ⊔ Y	es ⊔ No
Other/Concomitant Medication								kin or RAST tes	st to a pere	nnial aero	allergen		
	Allergies (please					Other Allergi							
Pretreatment serum IgE level _ Pretreatment FEV1 (if available			ined			sinophil leve mber of seve							
Pretreatment FEV1 (if available)													
				lea symptoms									
Ship to Address		*	lease list)										
ICD-10 Code			6	ad bu atata	la								
In order for a brand name por your state-specific requir	roduct to be d	dispensed, the p	rescribe	r must handv	vrite "Br						cations.		
MEDICATION	DOSE		DIREC	CTIONS								QTY	REFILLS
□ Nucala	□ 100 mg Vial		□Ped	liatric Severe A	sthma (6-	-11 years of a	ge): 40	mg SubQ to up	pper arm, t	high or ab	domen	28-Day	
	(Office Admi	nistered Only) Auto-Injector		e every 4 week ere Asthma in F					ients 18 yea	ars and old	der:	28-Day	
	□ 100 mg/mL		100	mg SubQ to u	pper arm	arm, thigh or abdomen once eve lients 12 years and older: Inject 3			e every 4 weeks			28-Day	
									abdomen once every 4 weeks			20-Day	
☐ Tezspire		ct 210 mg Sub0 te: Office/HCP								1			
	□ 210 mg/1.91 mL □ Inject: 210 mg				Q once e	very 4 weeks						1	
(110 mg/mL) Pre-filled Pen □ Xolair To be administered: □ By a healthcare professional □ In the Home If administered in the home, has patient received at least 3 doses of Xolair, under HCP guidance, with no hypersensitivity reactions? □ Yes □ No													
☐ Asthma (dose is dependent	□ Prefilled Syr			-		juluance, wit	i iio iiy	persensitivity	eactions:	L les L	140		Ī
on weight and IgE levels, see package insert: 75 to 375 mg every 2 or 4 weeks) □ CIU (fixed dose, not dependent on weight or IgE levels: 150 or 300 mg every 4 weeks) □ Nasal Polyposis (75 to 600 mg every 2 or 4 weeks)	Pharmacy to d amount of 75 r Syringes to co	lispense the least mg or 150 mg mplete total dose. in 75 mg and 150	Admir	□ Every 4 weeks dosing: Administer: □ 75 mg □ 150 mg □ 225 mg □ 300 mg □ 450 mg □ 600 mg □ Every 2 weeks dosing: Administer: □ 225 mg □ 300 mg □ 375 mg □ 450 mg □ 525 mg □ 600 mg							28 Day		
☐ Epinephrine	□ 0.3 mg		□ Inje	ct IM as needed	d for anap	ohylaxis							
□ EpiPen	□ 0.15 mg		□Oth			-							
Prescriber Signature			Date		_ Sı	upervising Ph	ysician	Signature (wh	ere require	d by state		Date	
DAW (Dispense as Written)			 Date			Brand Necessary (must handwrite)							

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