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	N .														
Last Name	First Name	DOB			Gender	□M □F	Last 4 SSN		Prir	rimary Language					
Address	'			City					State		ZIP				
Email	Home Phone		Worl	Work Phone Cell Phone											
Primary Contact Method (chec	ork Phone	□ Te	☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT												
Primary Caregiver/Alt Contact	Name (If applicable)		Alt Contac	t Email	I				Alt	Contact Pho	one				
PRESCRIBER INFORMA	TION														
Name of Contact Sending Refe	erral	Title	·			Pref	ferred Contact	Method (c	heck one)	☐ Email	☐ Phone	□ Fax			
Referral Contact Email		Office Pl	one			Office F	ax								
Practice / Facility Name					Prescrib	er Name /	Specialty								
Address	С	ity				s	tate	ZIP							
Prescriber State License #	icense # DEA #						NPI # Medicaid UPIN #								
* Please include a copy of the front and back of insurance card *															
CLINICAL INFORMATION - Please include applicable clinical chart notes															
	ve/New Start			0.00				Therapy S	tart Date						
Therapies Tried and Failed (ple		LAISTING	ireatiment					тпетару з	tart Date						
Sample/Starter Provided?	•	ate Provided:		Р	atient Heig	ht (cm/in)	ı. Wai	ght (kg/lb	ve).	Date Ob	stained:				
• •	ion training coordination required		acv2 □ Vos				s had Chronic I					os 🗆 No			
Other/Concomitant Medication		by our priarrie	acy: 🗆 ies								inore 🗆 i	=3 1140			
•	*						kin or RAST tes	st to a peri	ennai aero	allergen					
Allergies NKDA Drug Allergies (please list) Pretreatment serum IgE levelIU/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:															
□ Poor symptom control □ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months □ Asthma-related emergency treatment □ Airflow limitation □ Currently dependent on oral corticosteroids for treatment of asthma Ongoing Treatment - Positive response to treatment demonstrated by:															
☐ Reduction in frequency and/	or severity of relapses	tion or discon		f doses	of corticos	teroids an	d/or immunosu	uppressan	t						
Ship to Address ☐ Home ☐	Prescriber's Office	ease list)													
ICD-10 Code Code	Description		_												
In order for a brand name p	1ATION - Please Escribe if product to be dispensed, the p red language to prohibit subst	rescriber mu	ıst handw	rite "B						cations					
				iot a vi	allu presc	πρασπτο	orrir for writing	g control	nea mear	cations.	OTV	DEFILLS			
MEDICATION Cinqair	DOSE □ 100 mg/mL Vial	□ Infuse		(3 mg/	/kg x	_ kg) IV oı	nce every 4 we	eks			QTY 28 Day	REFILLS			
Asthma, severe eosinphilic	Patients and \$12 years	Unitial Da		100	. (2,,200						-				
☐ Dupixent Moderate-to-severe asthma	Patients aged >12 years ☐ 200 mg/1.14 mL PFS ☐ 200 mg/1.14 mL PEN	☐ Initial Dose: Inject 400 mg (2x200 mg) injections SubQ on Day 1 and 200 mg SubQ on Day 15									3	0			
	-	☐ Maintenance Dose: Inject 200 mg SubQ every 2 weeks									2				
	Patients aged >12 years ☐ 300 mg/2 mL PFS ☐ 300 mg/2 mL PEN	☐ Initial Dose: inject 600 mg (2x300 mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15									3	0			
	300 Hig/2 Hit PEN	□ Maintena	ance Dose:	Inject 3	ct 300 mg SubQ every 2 weeks						2				
	Patients aged 6-11 years (Weight:kg (1 kg = 2.2 lb)		0 mg SubG	every	y 2 weeks						2				
	Weight 15 kg to <30 kg ☐ 100 mg/0.67 mL PFS ☐ 300 mg/2 mL PFS	nject 300 mg SubQ every 4 weeks								1					
	Patients aged 6-11 years (Weight:kg (1 kg = 2.2 lb) Weight >30 kg ☐ 200 mg/1.14 mL PFS	□ Inject 200 mg SubQ every 2 weeks							2						
Prescriber Signature		Date		_			Signature (wh	ere requir	ed by state	e law) I	Date	_			
DAW (Dispense as Written)	Date			Brand Nece											

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)

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	1													
Last Name	First Name	DC	В		Gender □ M □ F			Last 4 SSN		Primary Language		anguage		
Address				City					State	State		ZIP	ZIP	
Email	Home Pho	ne		Work Phone						Cell Phone				
Primary Contact Method (chec	□Те	☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT												
Primary Caregiver/Alt Contact	Name (If applicable)		Alt Contac	ct Emai	I					Α	It Contac	t Phone		
PRESCRIBER INFORMA	TION													
Name of Contact Sending Refe	erral		Title				Prefe	erred Contact	Method (c	heck on	e) 🗆 En	nail 🗆 Pho	ne [□Fax
Referral Contact Email					Office	Phone				Office	Fax			
Practice / Facility Name					Prescri	ber Nar	me / 9	Specialty					1	
Address	DEA #				City						State		ZIP	
Prescriber State License #		NPI # Medicaid UPIN #												
	* Please in	clude a	copy of the	e fror	nt and	back	of	insurance	card *					
CLINICAL INFORMATIO	N - Please include appli	cable cli	nical chart n	otes										
Patient New to Therapy Naï	ve/New Start ☐ Therapy Rest	art 🗆 Exis	ting Treatment						Therapy S	tart Dat	е			
Therapies Tried and Failed (ple	ease list medications)													
Sample/Starter Provided? ☐ N	o ☐ Yes, Provide Qty:	Date Provi	ided:	P	atient He	ight (cr	n/in):	Wei	ight (kg/lb	s):	Dat	te Obtained:	:	
If Self-injectable drug, is inject	ion training coordination requir	ed by our p	harmacy? 🗆 Yes	□No		Patier	nt has	had Chronic I	diopathic	Urticaria	for 6 we	eks or more	☐ Yes	. □ No
Other/Concomitant Medication	ns (please list)				History	of posit	ive sk	in or RAST tes	st to a pere	ennial ac	eroallerge	n		
Allergies □ NKDA □ Drug A	Allergies (please list)				Other Al	lergies	(plea	se list)						
Pretreatment serum IgE level _ Pretreatment FEV1 (if available		te otained			osinophil			ailable) erbations in th						
•	n of asthma as uncontrolled or					0010.0	onao		, , , , , , , , , , , , , , , , , ,					
☐ Poor symptom control ☐	Two or more bursts of systemic reatment	corticoster	oids for at least	3 days e	each in th				thma					
	response to treatment demonst		entry dependent	On Ora	i corticos	teroius	101 111	eatment or ast	uiiiia					
☐ Reduction in frequency and/	or severity of relapses 🗆 Rec	luction or d		f doses	of cortic	osteroio	ds and	d/or immunosı	uppressant	:				
	Crion in severity or frequency o													
ICD-10 Code	Prescriber's Office Other	(please list)	1											
PRESCRIPTION INFORM		if requir	red by state	law										
In order for a brand name p	product to be dispensed, the	prescribe	er must handw	rite "E										
or your state-specific requi				not a v	alid pres	criptic	on foi	rm for writin	g control	led me	dication			
MEDICATION	DOSE		CTIONS									QTY		REFILLS
☐ Dupixent Oral CS-dependent	Patients aged >12 years ☐ 300 mg/2 mL PFS	□ Init	ial Dose: Inject 6	600 mg) mg (2x300 mg) injections on Day 1 and 300 mg SubQ on Day 15							;	3	0
asthma or co-morbid AD or adults with co-morbid	□ 300 mg/2 mL PEN	□ Ma	intenance Dose:	Inject 3	300 mg S	ubQ ev	ery 2	weeks					2	
rhinosinusitis w/nasal polyps	Patients aged 6-11 years (Weight: kg (1 kg = 2.2				mg (2x300mg) injections 0 mg SubQ on Day 15							;	3	0
	□ 300 mg/2 mL PFS				ect 300 mg SubQ every 4 weeks								1	
	Weight 30 kg to <60 kg				mg (2x200mg) injections									
	☐ 200 mg/1.14 mL PFS				0 mg SubQ on Day 15							,	3	0
		Inject 2	ect 200 mg SubQ every 2 weeks D mg (2x300mg) injections 10 mg SubQ on Day 15								2			
	Weight >60 kg ☐ 300 mg/2 mL PFS									;	3	0		
			Maintenance Dose: Inject 300 mg SubQ every 2 weeks										2	
☐ Dupixent	☐ 300 mg/2 mL PFS		ect 300 mg Sub				, -						_	
Chronic rhinosinusitis w/nasal polyposis	□ 300 mg/2 mL PEN	,		,									2	
□ Fasenra	☐ 30 mg/mL PFS	□Off	ice-Administere	d I oadi	ina Dose	Inject 3	30 ma	ı SubQ once e	very 4 wee	ks for 3	doses		3	0
Asthma, severe eosinphilic	□ 30 mg/mL PEN				ling Dose: Inject 30 mg SubQ once every 4 weeks for 3 doses nance Dose: Inject 30 mg SubQ once every 8 weeks						uoses		1	
		561				,			y v				-	
Prescriber Signature		Date		S	Supervisin	g Physi	ician S	Signature (whe	ere require	d by sta	te law)	Date		_
				_										
DAW (Dispense as Written)		Date		В	Brand Nec	essary	(must	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 (E-Z)

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 N	ame	DOB			Gender □ M □ F Last 4 SSN				guage				
Address					City					State	State ZIP			
Email		Home Phone					Phone	•				Cell Phon	ie	
Primary Contact Method (check	rimary Contact Method (check one)							Prin	mary Caregiv	er 🗆 D	O NOT C	ONTACT		
Primary Caregiver/Alt Contact N	act Emai	Email Alt Contact Phone												
PRESCRIBER INFORMATION														
Name of Contact Sending Refer		Title Preferred Contact Method (check one) □ Ema								e) 🗆 Emai	il 🗆 Phone	□ Fax		
Referral Contact Email	'			Office Pl	one				Office	Fax				
Practice / Facility Name						Prescribe	r Name	e / S	pecialty					
Address												State	ZIP)
Prescriber State License #		DEA #			N	NPI#					Medicai	d UPIN #		
* Please include a copy of the front and back of insurance card *														
CLINICAL INFORMATION - Please include applicable clinical chart notes														
										Therapy S	Shout Dob			
Patient New to Therapy Naïve			rt 🗆 Exis	ting freatment						Therapy s	start Date			
Therapies Tried and Failed (plea			Data Barri	d - d.			h /	/! > ·	14/-	:	> -	D-t-	0 -+-! -	
Sample/Starter Provided? ☐ No	· · · · · · · · · · · · · · · · · · ·		Date Provi			Patient Heig				ight (kg/lk			Obtained:	
If Self-injectable drug, is injection		dination require	d by our pl	narmacy? \square Ye									s or more 🗆 Y	es ⊔ No
Other/Concomitant Medications							-		n or RAST te	st to a per	ennial ae	roallergen		
	llergies (please					Other Alle			-					
Pretreatment serum IgE levelIU/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: □ Poor symptom control □ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months □ Asthma-related emergency treatment □ Airflow limitation □ Currently dependent on oral corticosteroids for treatment of asthma														
Ongoing Treatment - Positive re ☐ Reduction in frequency and/o ☐ Disease remission ☐ Reduc	r severity of re	apses 🗆 Redu	iction or di		of doses	of corticos	teroids	and,	or immunos/	uppressan	t			
	□ Disease remission □ Reduction in severity or frequency of EGPA-related symptoms Ship to Address □ Home □ Prescriber's Office □ Other (please list)													
ICD-10 Code ☐ Code	Description													
PRESCRIPTION INFORM			if requir	ed by state	law									
In order for a brand name pr or your state-specific require	oduct to be d	dispensed, the	prescribe	er must handv	vrite "E									
MEDICATION	DOSE		DIRE	CTIONS									QTY	REFILLS
□ Nucala	□ 100 mg Vial			liatric Severe A						pper arm,	thigh or	abdomen	28-Day	
	(Office Admi	nistered Only) Auto-Injector		ce every 4 weel ere Asthma in						ients 18 ye	ears and	older:	28-Day	
		mg SubQ to u							Iministar	z se ha	28-Day			
		☐ 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									20 Day			
☐ Xolair To be administered: If administered in the					der HCP	guidance,	with no	hyp	ersensitivity	reactions?	☐ Yes [□No		
☐ Asthma (dose is dependent	☐ Prefilled Syr			ry 4 weeks dos										
on weight and IgE levels, see package insert: 75 to 375 mg	Pharmacy to a amount of 75 i	lispense the least na or 150 ma	Admi	nister: 🗆 75 r	ng 🗆	150 mg □	225 mg	g [300 mg □	450 mg	□ 600 r	ng		
every 2 or 4 weeks)	Syringes to co	mplete total dos												
□ CIU (fixed dose, not dependent on weight or IgE	mg strengths.	n 75 mg and 150		ery 2 weeks dos nister: 🗆 225		300 mg	⊒ 375 n	ng	□ 450 mg	□ 525 mg	□ 600	mg	28 Day	
levels: 150 or 300 mg every	☐ 150 mg Sing	le Dose VIAI												
4 weeks)		ie Dose VIAL												
□ Nasal Polyposis (75 to 600 mg every 2 or 4 weeks)														
□ Epinephrine	□ 0.3 mg			☐ Inject IM as needed for anaphylaxis ☐ Other:										
□ EpiPen	□ 0.15 mg		Oth	ner:										
Prescriber Signature			Date		:	Supervising	Physic	ian S	Signature (wh	ere requir	ed by sta	ate law)	Date	
DAW (Dispense as Written)			Date			Brand Nece	ssary (r	must	: 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.