

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

Pharmacy: \_\_\_\_\_  
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/ $\mu$ L IgE Level \_\_\_\_\_ IU/mL Current Weight: \_\_\_\_\_  lb  kg Date: \_\_\_\_\_ Current Height: \_\_\_\_\_  in  cm Date: \_\_\_\_\_  
 Other Therapies Tried & Failed (Please List): \_\_\_\_\_  
Allergies: \_\_\_\_\_

## PRESCRIPTION INFORMATION

**Cinqair (reslizumab) 100 mg/10 mL vial**  
3 mg/kg once every 4 weeks by intravenous infusion over 20 to 50 minutes. To be administered by a healthcare professional.  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Dupixent (dupilumab) 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.  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Dupixent (dupilumab)**  
 300 mg/2 mL pre-filled syringe  300 mg/2 mL pre-filled pen  
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: \_\_\_\_\_

**Fasenra (benralizumab) 30 mg/mL pre-filled syringe**  
30 mg administered once every 4 weeks for the first 3 doses, and then once every 4 weeks thereafter by subcutaneous injection into the upper arm, thigh or abdomen.  
To be administered by a healthcare professional.  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Fasenra (benralizumab) 30 mg/mL Pen**  
30 mg 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: \_\_\_\_\_

**Other:** \_\_\_\_\_  
Directions: \_\_\_\_\_  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Nucala (mepolizumab)**  
 100 mg vial  100 mg/mL pre-filled autoinjector  100 mg/mL pre-filled syringe  
 To be administered by a healthcare professional.  
**SEVERE ASTHMA**  
 100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen.  
 40 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen.  
**EOSINOPHILIC GRANULOMATOSIS WITH POLYAGNIITIS (EGPA)**  
 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh or abdomen.  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Xolair (omalizumab) 150 mg vial kit**  
 Supply Kit  
(#2) 18g 1 & 1/2 syringe 3ml  
(#2) 25g 5/8 safety needle  
(#2) alcohol swabs

**Xolair PFS (omalizumab)**  
 75 mg/0.5 mL pre-filled syringe  150 mg/1 mL pre-filled syringe  
 To be administered by a healthcare professional.  
**SHIPPING TO THE HOME:** Has patient received at least 3 doses of Xolair under the guidance of a healthcare provider with no hypersensitivity reactions?  Yes  No

Every 4 weeks dosing:	Every 2 weeks dosing:
<input type="checkbox"/> 75 mg per dose subcutaneously every 4 weeks.	<input type="checkbox"/> 225 mg per dose subcutaneously every 2 weeks.
<input type="checkbox"/> 150 mg per dose subcutaneously every 4 weeks.	<input type="checkbox"/> 300 mg per dose subcutaneously every 2 weeks.
<input type="checkbox"/> 225 mg per dose subcutaneously every 4 weeks.	<input type="checkbox"/> 375 mg per dose subcutaneously every 2 weeks.
<input type="checkbox"/> 300 mg per dose subcutaneously every 4 weeks.	

Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

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

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.