Asthma/Allergy Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

1. Patient Information

Patient Name: ________________________ Birthdate: __________ Sex: O Male O Female Weight_____________ O lbs. O kg
Preferred Phone: ____ Known Allergies____
Address: ____ City: _________________ State_____________ Zip: ____________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name: ____ NPI#________________________ Tax ID#______________________
Address: ____ Phone: ______________________ Fax: _______________________
City, State, Zip: ____ Key Contact: ____

3. Diagnosis/Clinical Information

Diagnosis: ____ ICD-10___________

Does the patient have:

Eosinophilic Phenotype Asthma	O Yes	O No
Steroid Dependent Asthma	O Yes	O No
History of asthma exacerbations that require treatment with systemic corticosteroids	O Yes	O No
Emergency dependent visit or hospitalization for treatment of asthma within the last year	O Yes	O No
Dependence on daily oral corticosteroids in addition to regular use of high-dose inhaled corticosteroids	O Yes	O No

	Baseline	Current
FEV_1:	________________	________________
Asthma AQ-5	________________	________________
Asthma AQLQ	________________	________________
Eosinophil Count	________________	________________

Patient's History of Current Therapy
Medication(s) Dose/Duration:
____
____
____

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
☐ AUVI-Q® (epinephrine injection, USP)	☐ 0.15 mg ☐ 0.3 mg	☐ Inject one injector into outer thigh IM for anaphylaxis. Press firmly and hold for 5 seconds. Call 911. ☐ Inject one injector into outer thigh IM for anaphylaxis. May repeat one time after minutes. Call 911.	**1** Carton = 2 autoinjectors and 1 Trainer **2** Cartons = 4 autoinjectors and 2 Trainers	_____
☐ Dupixent® (Dupilumab)	☐ 300 mg/2 ml Prefilled Syringe ☐ 200 mg/1.14 ml	☐ Starter Dose: 600mg SC divided in 2 different injection sites ☐ Maintenance dose: 300mg SC every other week ☐ Starter Dose: 400mg SC divided in 2 different injection sites ☐ Maintenance dose: 200mg SC every other week	__________	_____
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐				

Dispensing Options: ☐ Pick-Up | Deliver To: ☐Patient's Home ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below

Date

____ ______________________________

I authorize Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressees and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.