ALLERGIC SPECIALTY MEDICATIONS FORM

PATIENT INFORMATION

Last Name ______ First Name ______

Social Security No ______ Date of Birth ______

Sex □ M □ F Weight_____ Height_____ Allergies__________

Home Phone ______ Work/Mobile ______

Home Address ______

City ______ State ______ Zip ______

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______ Medical Insurance Phone ______

Subscriber Name ______

Rx Card (PBM) ______ Group No ______

Prescription Card Bin # ______ PCN # ______

TREATMENT ARRANGEMENTS

•Start Date:______________ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Doctor's Office □ Other:______________________

CERTIFICATE OF MEDICAL NECESSITY

Diagnosis (ICD-10): □ J45.40 Moderate persistent asthma uncomplicated □ J45.50 Severe persistent asthma uncomplicated □ L20.9 Atopic dermatitis

Serum total immunoglobulin E (IgE) level (IU/mL) __________ Body Weight: ________

□ Other: ____

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTION	QUANTITY	REFILLS
□ **DUPIXENT®** **(dupilumab)**	□ 300mg/2ml Prefilled Syringe	□ Inject 600mg (2 Prefilled Syringe) Subq in different sites on day 1. □ Inject 300mg (1 Prefilled Syringe) Subq every other week starting day 15 after initial dose. □ Others: ______________________		
□ **XOLAIR®** **(omalizumab)** □ **Vial** □ **Prefilled Syringe**	□ 75mg □ 150mg □ 225mg □ 300mg □ 375mg	□ Inject ________mg/dose Subq every 2 weeks. □ Inject ________mg/dose Subq every 4 weeks. □ Others: ______________________		
□ **NUCALA®** **(mepolizumab)**	□ 100mg	□ Inject 100mg Subq once every 4 weeks. □ Others: ______________________		
□ **CINQAIR®** **(reslizumab)**	□ ______mg/kg	□ Inject _______mg/kg once every 4 weeks by intravenous infusion over 20-50 minutes. □ Others: ______________________		
□ **FASENRA®** **(benralizumab)**	□ 30mg	□ Inject 30mg Subq every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter. □ Others: ______________________		
□	□	□		

□ ***Skilled nursing visit for self injection training and one additional visit with next dose if needed.***

Physician Signature X:______________________ □ **DAW (Dispense as Written) Date**:______________

Physician Name: ______________**Phone:** ______________**Fax:** ______________**Office Contact:** ______________

Physician Address: ______________________ **NPI:** ______________**DEA:** ______________

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