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)**	□ 150mg □ 225mg □ 300mg □ 375mg	□ Inject _____mg Subq every 2 or 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:** _____

By Signing this prescription and using Southside pharmacy's services you authorize Southside Pharmacy to contact Insurance companies for prior authorization purposes on your behalf.

Fax your referral to (470) 377-4055

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