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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