



## Asthma and Allergy

Delivery Need By: \_\_\_\_\_ Deliver to:  Patient's Home  Physician's Office  Other

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Last Four of Social: \_\_\_\_\_ DOB: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_  
Office Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_  
DEA/NPA #: \_\_\_\_\_

## INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

### CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_  
ICD-10 Code: \_\_\_\_\_  
Height: \_\_\_\_\_ ft \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs  
Allergies: \_\_\_\_\_

Has the patient been treated previously for this condition?  
 Yes  No  
Medications Failed: \_\_\_\_\_  
Medications On: \_\_\_\_\_  
Other Notes: \_\_\_\_\_

### PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Cinqair®	<input type="checkbox"/> 100MG/10ML VIAL	<input type="checkbox"/> Inject _____ mg (3mg/kg) every 4 weeks by IV infusion	<input type="checkbox"/> _____ Vials <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other	
Dupixent®	<input type="checkbox"/> 200 mg/1.14 mL solution in a single-dose pre-filled syringe <input type="checkbox"/> 200 mg/1.14 mL solution in a single-dose pre-filled syringe	<u>Loading Dose:</u> <input type="checkbox"/> Inject 400 mg (two 200 mg injections) SC <input type="checkbox"/> Inject 600 mg (two 300 mg injections) SC	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 200 mg SC every other week <input type="checkbox"/> Inject 300 mg SC every other week	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other
Xolair®	<input type="checkbox"/> 75 mg/0.5 mL in a single-dose prefilled syringe <input type="checkbox"/> 150 mg/mL solution in a single-dose prefilled syringe <input type="checkbox"/> 150 mg lyophilized powder in a single-dose vial for reconstitution	<input type="checkbox"/> Inject _____ mg SC every 2 weeks <input type="checkbox"/> Inject _____ mg SC every 4 weeks <input type="checkbox"/> Other	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other	
Other				
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration		

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_