



Asthma Enrollment Form

Fax Referral Form To: 1-781-805-8245
Specialty Pharmacy Phone: 1-844-319-7588

Please fill out the following 6 areas to submit a referral:

1 PATIENT INFORMATION

Patient Name		Date of Birth
Address		Primary Phone
City	State	Alternate Phone
ZIP	Gender Male Female	Email
Primary Language		

2 PRESCRIBER INFORMATION

Prescriber's Name	License #
DEA #	NPI
Group or Hospital Name	Contact Person
Address	Phone
City, State, ZIP	Fax

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with applicable pre-authorization approvals with this form, if available

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: **Medical Office OR Patient OR Other:** _____
(ALL orders will be shipped to medical facility listed unless otherwise indicated)

Diagnosis Code J45.4 - Moderate Persistent Asthma
 J45.5 - Severe Persistent Asthma
 Other Code: _____ Description: _____

Height: _____ in/cm Weight: _____ kg/lbs Allergies: _____ IgE Level: _____

5 PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Xolair® (omalizumab)	<input type="checkbox"/> 150 mg vial kit	Every 4 weeks dosing: <input type="checkbox"/> Administer 75 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 150 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 225 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 300 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Other: Administer _____ mg per dose subcutaneously every 4 weeks Every 2 weeks dosing: <input type="checkbox"/> Administer 225 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Administer 300 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Administer 375 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Include sterile water and supplies sufficient for medication days supply > One 10ml vial sterile water for injection for every vial of Xolair® dispensed > Alcohol swabs > NDL 18G x 1 1/2" safety glide needle for reconstitution > NDL 25G x 5/8" safety glide needle for subcutaneous injection <input type="checkbox"/> No supplies (above supplies provided unless indicated)	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> ___-day supply	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
I certify that the rationale for Xolair® therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.				
<input type="checkbox"/> Nucala® (mepolizumab)	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Inject 100mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen <input type="checkbox"/> Include sterile water and supplies sufficient for medication days supply > One 10ml vial sterile water for injection for every vial of Nucala dispensed > Alcohol swab > 3mL Luer Lock injection syringe > NDL 21G needle for reconstitution > 1mL polypropylene syringe with 21G to 27G x 1/2" needle for subcutaneous injection <input type="checkbox"/> No supplies (above supplies provided unless indicated)	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> ___-day supply	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Epipen®		<input type="checkbox"/> Use as directed.	#1	
<input type="checkbox"/> Epipen® Jr.		<input type="checkbox"/> Use as directed.	#1	

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STAMP SIGNATURE NOT ALLOWED
PHYSICIAN SIGNATURE REQUIRED

X _____ X _____
 Product Substitution Permitted Date Dispense as Written (DAW) Date