Allergy-Immunology Enrollment Form

Fax: 909-284-9140
Phone: 909-266-0016
□ **Urgent Request**
Rep: _____

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***
Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Mobile Phone _____
DOB _____ Last Four of SS _____ Gender _____
Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
DEA _____
NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis - Please include diagnosis name with ICD-10 code	Additional information	Therapy □ New □ Reauthorization □ Restart

□ L20.9 Atopic Dermatitis □ J45.50 Severe persistent asthma uncomplicated □ L50.1 chronic idiopathic urticaria
□ Other Diagnosis: ICD-10 Code _____
Description _____
Date of Diagnosis _____
Estimated length of therapy _____

Weight _____ kg/lbs. Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
□ Dupixent	□ 200mg/2ml PFS □ 200mg/2ml Pens □ 300mg/2ml PFS □ 300mg/2ml Pens	□ Inject 400mg SQ on day 1 followed by 200mg SQ every 2 weeks thereafter □ Inject 200mg SQ every 2 weeks (maintenance) □ Inject 600mg SQ on day 1 followed by 300mg SQ every 2 weeks (Initial) □ Inject 300mg SQ every 2 weeks (maintenance)	□ 28 days	
□ Eucrisa	□ 2% ointment	□ Apply a thin layer to affected area(s) 2 times daily	□ 60 gm □ 100 gm	
□ Fasenra	□ 30mg Vial	□ Inject 30mg every 4 weeks for the first 3 doses (Initial) □ Inject 30mg every 8 weeks (maintenance)		
□ Nucala	□ 100mg Vial	□ Inject 100mg SQ once every 4 weeks into the upper arm, thigh or abdomen		
□ Xolair	□ 150mg Vial			
□ Other				

Ship to: □ Patient □ Office □ Other _____ Date: _____ Need by Date _____

**** Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature: _____ Date: _____