

Prescriber Information

Prescriber Name:				MD	DO	NP	PA	NPI:
Office Contact:				Practice Name / Collaborating MD:				
Address:			City:			State:		Zip:
Phone:		Fax:						

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patients Name:		Last 4 Digits of SS#:		DOB: / /	Sex: M F	Weight:	Height:	Diabetic? Y N
Address:			City:			State:		Zip:
Home Phone:		Work/Cell:		HIPAA Contact:			Emergency #:	
Interpreter Needed? Y N	Allergies: Y N If Yes, list allergies:							

Insurance Information

Primary Insurance:		Policy ID:	Group #:	BIN:	PCN:
Policyholder Name:			Policyholder DOB: / /		

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	Pulmonary Eosinophilia (J82) Moderate Persistent Asthma, uncomplicated (J45.40) Severe Persistent Asthma, uncomplicated (J45.50) Idiopathic Urticaria (L50.1)							
Atopic Dermatitis (L20.9)		Nasal Polyp (J33. _____)		Eosinophilic esophagitis (K20)		Other:		FEV1: %
Pre-treatment serum IgE: < 30 IU/mL ≥30-100 IU/mL > 100-200 IU/mL > 200-300 IU/mL > 300-400 IU/mL > 400-500 IU/mL > 500-600 IU/mL > 600-700 IU/mL								
Patient medical history includes: Positive RAST Positive skin test to perennial aeroallergen Asthma with eosinophilic phenotype Other:								
Current maintenance treatment (include dose and frequency):							Patient is a smoker or is exposed to smoke in the home: Y N	
Current exacerbation treatment (include dose and frequency):								
Prior Treatment? Y N (Provide Information Below)	BSA Affected (%):		Affected Areas: Palms Soles Head Neck Genitalia Other:					
Prior Therapy:			Reason for Discontinuation of Therapy:				Approx. Start Date: / /	
							Approx. End Date: / /	
Comorbidities:			Concomitant Medications:					

Prescription Information

Medication	Quantity/Dose	Sig	Refills
EBGLYSS™	QS for appropriate month of starter dose schedule	Starter Dose: Inject 500mg (two 250mg injections) SQ at week 0 and 2, then 250mg SQ every 2 weeks until week 16 or later (when adequate clinical response is achieved)	4 Refills
	1 carton (1x250mg/2ml)	Maintenance Dose: Inject 250mg SQ every 4 weeks	
FASENRA® Pen PFS	Pediatrics age 6-11 years: Weight < 35kg: 1 carton (10mg/0.5ml) PFS ONLY Weight ≥ 35kg: 1 carton (30mg/ml)	Starter Dose: Pediatrics age 6-11 years: Weight <35kg: Inject 10mg SQ every 4 weeks for the first 3 doses, followed by every 8 weeks thereafter Weight ≥35kg: Inject 30mg SQ every 4 weeks for the first 3 doses, followed by every 8 weeks thereafter Adults & Adolescents ≥ 12 years: Inject 30mg SQ every 4 weeks for 3 doses, followed by every 8 weeks thereafter	
	Adults & Adolescents ≥ 12 years: 1 carton (1x40mg/0.4ml)	Maintenance Dose: Pediatrics age 6-11 years: Weight <35kg: Inject 10mg every 8 weeks Weight ≥35kg: Inject 30mg SQ every 8 weeks Adults & Adolescents ≥ 12 years: Inject 30mg SQ every 8 weeks EGPA: Inject 30mg SQ every 4 weeks	
ILARIS®	1 vial (1x150mg/ml) 2 vials (2x150mg/ml)	Inject ____ mg SQ once every ____ weeks	

Injection Training

Patient received injection training	Prescriber's office to provide injection training	Meijer to coordinate injection training
-------------------------------------	---	---

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature	Date	Prescriber Signature	Date
----------------------	------	----------------------	------

Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.