meijer specialty pharmacy

P: 800-657-2212 • F: 888-592-7723
www.meijerspecialtypharmacy.com

○ New/Changed Dose

Allergy/Asthma (F-Z)

Fasenra®, Nucala®, Rinvoq™, Xolair®

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:	HIPPA 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
○ **FASENRA®**	○ 1 carton (30mg/mL) PFS ○ 1 carton (30mg/mL) PEN	**Starter Dose:** ○ Inject 30mg SQ every 4 weeks for the first 3 doses	**2**
	○ 1 carton (30mg/mL) PFS ○ 1 carton (30mg/mL) PEN	**Maintenance Dose:** ○ Inject 30mg SQ every 8 weeks	
○ **NUCALA®** **Pediatric Asthma (patients 6-11 years old)* ○ Vial ○ PFS ○ **Sterile water for injection** (to be used with Nucala vials) **Number of vials:** _____ **Refills:** _____	○ **PFS:** 1 carton (1x40mg/0.4ml) ○ **Vial:** 1x100mg	○ Inject 40mg subcutaneously once every 4 weeks	
○ **NUCALA®** **Asthma (12 years and older) & CRSwNP (adults)* ○ Autoinjector ○ PFS ○ Vial ○ **Sterile water for injection** (to be used with Nucala vials) **Number of vials:** _____ **Refills:** _____	○ **PFS:** 1 carton (1x100mg/ml) ○ **Autoinjector:** 1 carton (100mg/ml) ○ **Vial:** 1x100mg	○ Inject 100mg subcutaneously once every 4 weeks	
○ **NUCALA®** **HES (patients 12 years and older) and EGPA (adults)* ○ Autoinjector ○ PFS ○ Vial ○ **Sterile water for injection** (to be used with Nucala vials) **Number of vials:** _____ **Refills:** _____	○ **PFS:** 3 cartons (1x100mg/ml) ○ **Autoinjector:** 3 cartons (100mg/ml) ○ **Vial:** 3x100mg	○ Inject 300mg subcutaneously once every 4 weeks	
○ **RINVOQ™**	○ 15mg tablet (30 day supply) ○ 30mg tablet (30 day supply)	○ Take 1 tablet by mouth daily	
○ **XOLAIR®** ○ PFS ○ Vial ○ **Sterile water for injection** (to be used with Xolair vials) **Number of vials:** _____ **Refills:** _____	○ **PFS:** Number of 75mg/0.5ml syringes: _____ ○ **PFS:** Number of 150mg/ml syringes: _____ ○ Number of 150mg vials: _____	○ Inject _____ mg SQ once every _____ weeks	
○ **Other:**			

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.