elixir
SPECIALTY PHARMACY

Allergic Asthma Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ **New to Therapy**
☐ **Current Therapy**

Patient Information

Patient Name: _____
Date of Birth: _____ Gender: _____ SS#_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Patient Weight: _____☐kg/☐lbs Patient Height: _____☐in/☐cm
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder:_____
Policy holder Employer:_____
Relationship to Patient:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____

Prescriber Information

Practice/ Organization Name: _____
Physician Name: _____
Contact Person: _____ Contact's Phone: _____
Address:_____ _____
City: _____ State: _____ Zip: _____
Office Phone#:_____ Office Fax#:_____
DEA#_____ NPI#_____
License#:_____ Medicaid UPIN#:_____
Physician Specialty: _____
Date Shipment Needed: _____
Ship to: ☐**Patient** ☐**Prescriber** ☐**Other**_____
Shipment Address: _____ Attn: _____
City: _____State: _____Zip:_____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Diagnosis and Clinical Information

Diagnosis (ICD-10): ☐ J82 Pulmonary eosinophilia ☐ J45.4 Moderate Persistent Asthma ☐ J45.5 Severe Persistent Asthma ☐ D72.119 Hypereosinophilic syndrome (HES)
☐ M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA) ☐J33.0 Polyp of the nasal cavity ☐J33.1 Polypoid sinus degeneration ☐ J33.8 Other polyp of sinus
☐ J33.9 Nasal polyp, unspecified ☐K20.0 Eosinophilic esophagitis (EOE) ☐ Other:_____ Description: _____
Date of Diagnosis or Years with Disease: _____
Patients Allergies: _____ Latex allergy: ☐Yes ☐No
Comorbidities: _____
Lab Results (attach if available): ☐ Past positive skin or RAST test to perennial aeroallergen Pre-treatment: Serum IgE level: _____ IU/ML Testing date: _____
Serum eosinophils: _____cells/mcL; Sputum eosinophils: _____ Testing date: _____
Previous and Current Medication Use: _____
☐ Short-acting beta agonist ☐ Long-acting beta agonist ☐ Antihistamines ☐ Decongestants ☐ Immunotherapy ☐ Inhaled corticosteroids ☐ Leukotriene modifiers
☐ Oral steroids ☐ Nasal steroids ☐ Other: _____
Expected First Dose Date: _____ Injection training needed: ☐ Yes ☐ No EpiPen on hand for Patient: ☐ Yes ☐ No
Shipment to Patient ☐ Yes ☐ No Shipment to Provider: ☐ Yes ☐ No Shipment Address: _____

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Patient Name: _____ **Patient Date of Birth:** _____

Prescriber Name: _____ **Office Phone:** _____ **Date:** _____

Prescriber Address: _____

☐ **Cinqair®** (reslizumab) 100mg/10mL single-use vial

☐ 3mg/kg ☐ Other: _____

To be given by IV infusion once every 4 weeks by prescriber as directed.

☐ **Dupixent®** (dupilumab) ☐ Prefilled Syringe ☐ Prefilled Pen

☐ 100mg/0.67mL ☐ 200mg/1.14mL ☐ 300mg/2mL **Patient weight:** _____

☐ Starter: Inject 600mg SC day 1 then 300mg SC on day 15
☐ Starter: Inject 400mg SC on day 1 then 200mg SC on day 15
☐ Starter: Inject 600mg SC day 1 then 300mg SC every 4 weeks
☐ Maintenance: Inject 300mg SC every 2 weeks
☐ Maintenance: Inject 200mg SC every 2 weeks
☐ Maintenance: Inject 100mg SC every 2 weeks
☐ Maintenance: Inject 300mg SC every 4 weeks
☐ Maintenance: Inject 300mg SC every week
☐Other: _____

☐ **Nucala®** (mepolizumab) ☐100mg/mL Vial ☐100mg/mL Prefilled Syringe
☐100mg/mL Auto-Injector ☐40mg/0.4mL Prefilled Syringe
☐ Inject 100mg subcutaneously once every 4 weeks.
☐ Inject 40mg subcutaneously once every 4 weeks.

☐ **Xolair®** (omalizumab) ☐75mg Prefilled syringe ☐150mg Prefilled syringe ☐150mg vial
☐ To be injected subcutaneously once every 4 weeks as directed:
☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ Other: _____
☐ To be injected subcutaneously once every 2 weeks as directed:
☐ 225 mg ☐ 300 mg ☐ 375 mg ☐ Other: _____
☐ Other: _____

☐ **Sterile Water for Injection**

To be used as directed to reconstitute ☐ **Xolair®** ☐ **Nucala®** vials

Quantity: _____ vial(s) Refills: _____

☐ **EpiPen** ☐ **EpiPen Jr**

Use as directed for anaphylaxis

Quantity: 2 Pens Refills: _____

****If additional ancillary supplies needed, please send additional prescriptions.****

Dispense Quantity:_____ **Refills:** _____

Prescriber Signature: *X*_____

If Brand required "Dispense as Written" must be handwritten.