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: _________ Sex: M or F Caregiver: ____________________
Address: ____________________
City: ______________ State: __________ Zip: __________
Home Phone: ______________ Work Phone: ______________
Cell Phone: ______________ E-mail: ______________
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: ____________________
Prescriber Name: ____________________
Address: ____________________
City: ______________ State: __________ Zip: __________
Phone#: ______________ 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 prescriber's office, Prescriber accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis: ☐ J82 Pulmonary eosinophilia ☐ J45.______ ☐ Other: __ __ __ . __ __
Date of Diagnosis or Years with Disease: ____________________
Patients Allergies: ____________________
Latex allergy: ☐Yes ☐No Patient Weight: __________ Patient Height: __________
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

☐ **Dupixent®** (dupilumab) ☐ 200 mg pre-filled syringe ☐ 300 mg pre-filled syringe ☐300 mg Pen-Injector
☐ Starter: Inject 2 syringes subcutaneously on day 1 then 1 syringe on day 15
☐ Maintenance: Injection 1 syringe subcutaneously every 2 weeks

☐ **Nucala®** (mepolizumab) Inject 100 mg subcutaneously once every 4 weeks.
☐100 mg vial ☐100 mg pre-filled syringe ☐100 mg auto-injector

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

☐ **Cinqair®** (reslizumab, 100 mg/10mL single-use vial)
☐ 3 mg/kg ☐ Other: ______________
To be given by IV infusion once every 4 weeks by prescriber as directed.

Quantity Prescribed: ☐ QS 30 days ☐ Other: ______________
Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 11 ☐Other: ______________

X____________________ ____/____/________

Physician Signature (no stamps) **Date**

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