



## Asthma/Respiratory Enrollment Form

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PATIENT INFORMATION				
Name:		Date of Birth:		O Male    O Female
Address:		City:	State:	Zip:
Phone:		Alt Phone:		Email:
SS #:		Primary Language:		Emergency Contact:
PRESCRIBER INFORMATION				
Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:		City:	State:	Zip:
Phone:		Fax:		Office Contact:
MEDICAL INFORMATION				
<b>** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **</b>				
ICD-10 Code & Description: _____				
<b>Patient Evaluation:</b> Height: _____ in/cm    Weight: _____ kg/lbs Allergies: _____ Eosinophils: _____ Steroid Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Needs by Date:</b> _____    Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Other: _____				
PRESCRIPTION INFORMATION				
Drug	Dose	Directions	Qty/Day Supply	Refills
<input type="checkbox"/> Dupixent (duplimumab)	<input type="checkbox"/> 200mg/1.14mL PFS <input type="checkbox"/> 300mg/2mL PFS (COMES 2/BX)	<b>Initial dose:</b> <input type="checkbox"/> Inject 2 doses SC (different injection sites) initially then 1 dose SC every other week  <b>Maintenance dose:</b> <input type="checkbox"/> Inject 1 dose SC every other week	Qty _____  Day supply: _____	
<input type="checkbox"/> Fasenra (benralizumab)	<input type="checkbox"/> 10mg/0.5ml PFS <input type="checkbox"/> 30mg/mL PFS <input type="checkbox"/> 30mg/mL autoinjector	<input type="checkbox"/> Inject 10mg/0.5ml subcutaneously every 4 weeks for 3 doses, followed by once every 8 weeks thereafter <input type="checkbox"/> Inject 30mg/mL subcutaneously every 4 weeks for 3 doses, followed by once every 8 weeks thereafter <input type="checkbox"/> Other: Admin _____  <b>Eosinophilic Granulomatosis w/Polyangiitis (EFPA)</b> <input type="checkbox"/> Inject 30mg subcutaneously every 8 weeks  Note: PFS is administered by healthcare provider. Autoinjector can be self-admin or by caregiver if patient is 12yrs of age & weighs more than 35kg.	Qty _____  Day supply: _____	
<input type="checkbox"/> Tezspire (Tezepelumab)	<input type="checkbox"/> 210mg/1.91ml (110mg/ml) PFS <input type="checkbox"/> 210mg/1.91ml (110mg/ml) PF pen	<input type="checkbox"/> Inject 210mg subcutaneously every 4 weeks	Qty _____  Day supply: _____	
<input type="checkbox"/> Nucala (mepolizumab)	<input type="checkbox"/> 100mg vial <input type="checkbox"/> 100mg/mL autoinjector <input type="checkbox"/> 100mg/mL PFS <input type="checkbox"/> 40mg/0.4ml PFS	<input type="checkbox"/> (12 years and older): Inject 100mg administered subcutaneously once every 4 weeks <input type="checkbox"/> Severe asthma (6 to 11 years): Inject 40mg administered subcutaneously once every 4 weeks <input type="checkbox"/> Inject 300mg as 3 separate 100mg subcutaneously inactions once every 4 weeks  <input type="checkbox"/> No supplies requested (supplies will be sent w/shipment unless indicated)	Qty _____  Day supply: _____	

		<input type="checkbox"/> Include sterile water & supplies sufficient for medication days supply <ul style="list-style-type: none"> <li>• 10ml vial sterile water for injection (1 per vial ship)</li> <li>• Alcohol swabs</li> <li>• 3ml syringe w/ 21G x 1" safety glide needle for reconstitution</li> <li>• 1ml syringe w/ 27G x 1/2" safety glide needle for SQ injection</li> </ul>		
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#### INJECTION TRAINING

☐ Patient has received pen & injection training
☐ Physician's office to provide injection training
☐ Pharmacy to coordinate injection training

#### PRESCRIBING PRACTITIONER SIGNATURE

**Prescribing Practitioner:** The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing this form and utilizing our services, you are also authorizing Medford Chemists Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

☐ DAW Brand Medically Necessary
☐ May substitute/ Substitution Permissible

Prescribing Practitioner

Date

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