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:	Tax ID:
Phone:	Fax:			Office Contact:

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

ICD-10 Code & Description: _____

Patient Evaluation: Height:_____ in/cm Weight: _____ kg/lbs

Allergies: _____

Eosinophils: _____

Steroid Dependent: ☐ Yes ☐ No

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

PRESCRIPTION INFORMATION

Drug	Dose	Directions	Qty/Day Supply	Refills
☐ Dupixent (dupliumab)	☐ 200mg/1.14mL PFS ☐ 300mg/2mL PFS (COMES 2/BX)	**Initial dose:** ☐ Inject 2 doses SC (different injection sites) initially then 1 dose SC every other week **Maintenance dose:** ☐ Inject 1 dose SC every other week	Qty_____ Day supply: _____	
☐ Fasenra (benralizumab)	☐ 10mg/0.5ml PFS ☐ 30mg/mL PFS ☐ 30mg/mL autoinjector	☐ Inject 10mg/0.5ml subcutaneously every 4 weeks for 3 doses, followed by once every 8 weeks thereafter ☐ Inject 30mg/ml subcutaneously every 4 weeks for 3 doses, followed by once every 8 weeks thereafter ☐ Other: Admin _____ **Eosinophilic Granulomatosis w/Polyangiitis (EFPA** ☐ 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: _____	
☐ Tezspire (Tezepelumab)	☐ 210mg/1.91ml (110mg/ml) PFS ☐ 210mg/1.91ml (110mg/ml) PF pen	Inject 210mg subcutaneously every 4 weeks	Qty_____ Day supply: _____	

☐ Nucala (mepolizumab)	☐ 100mg vial ☐ 100mg/mL autoinjector ☐ 100mg/mL PFS ☐ 40mg/0.4ml PFS	☐ (12 years and older): Inject 100mg administered subcutaneously once every 4 weeks ☐ Severe asthma (6 to 11 years): Inject 40mg administered subcutaneously once every 4 weeks ☐ Inject 300mg as 3 separate 100mg subcutaneously inactions once every 4 weeks ☐ No supplies requested (supplies will be sent w/shipment unless indicated) ☐ Include sterile water & supplies sufficient for medication days supply • 10ml vial sterile water for injection (1 per vial ship) • Alcohol swabs • 3ml syringe w/21Gx1" safety glide needle for reconstitution • 1ml syringe w/ 27G x ½" safety glide needle for SQ injection	Qty_____ Day supply: _____	

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

CONFIDENTIALITY NOTICE

Medford Chemists