Kohll's Rx SPECIALTY CARE

ASTHMA SPECIALTY CARE PROGRAM

Phone: **877-324-2501** • Fax: **888-972-4110**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____
Other: _____ Date: _____
Assessment: ❑ Moderate ❑ Moderate to Severe ❑ Severe
Number of severe exacerbations in the past 12 months that required systemic corticosteroids, ER visits or hospitalizations: _____
Blood Eosinophil Level: _____ Test Date: _____
IgE Level: _____ Test Date: _____
FEV1 Level: _____ Test Date: _____
Positive sensitivity to allergens on Allergy test? ❑ Yes ❑ No
(Xolair® is FDA approved for allergic asthma, the FDA/PA criteria requests that the patient has positive skin or in-vitro reactivity to at least one perennial allergen)
Prescribed by/in consultation with ❑ Pulmonologist ❑ Allergist ❑ Immunologist
❑ Other: _____

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Biologics	_____
❑ ICS	_____
❑ ICS + LABA	_____
❑ LABA	_____
❑ Oral/Injectable Corticosteroids	_____
❑ Other Controllers	_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING:

❍ To Be Administered in a Health Care Setting (for Xolair®) ❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training
❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ DUPIXENT®	❑ 200mg/1.14ml Prefilled Syringe	**For adults and adolescents 12 years of age and older:**		
		❑ **Induction Dose:** Inject 400mg SC on day one	2	0
		❑ **Maintenance:** Inject 200mg SC every other week	2	
	❑ 300mg/2ml Prefilled Syringe	❑ **Induction Dose:** Inject 600mg SC on day one	2	0
		❑ **Maintenance:** Inject 300mg SC every other week	2	
		For patients who require concomitant oral corticosteroids or with comborbid moderate to severe atopic dermatitis for which Dupixent® is indicated, start with an initial dose of 600mg SC followed by 300mg SC given every other week		
❑ XOLAIR®	❑ 75mg/0.5ml Prefilled Syringe ❑ 150mg/1ml Prefilled Syringe ❑ 150mg/1.2ml Lyophilized Powder Vial	❑ Inject 75mg SC every 4 weeks ❑ Inject 150mg SC every 4 weeks ❑ Inject 225mg SC every 2 weeks ❑ Inject 225mg SC every 4 weeks ❑ Inject 300mg SC every 2 weeks ❑ Inject 300mg SC every 4 weeks ❑ Inject 375mg SC every 2 weeks ❑ Other: _____		
❑ _____	_____	_____		

PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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