

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: _____ Secondary Diagnosis: _____ Date: _____

Diagnosis of moderate-to-severe asthma in patients ≥12 years old

Diagnosis of moderate-to-severe eosinophilic asthma in patients ≥12 years old

Diagnosed by: Pulmonary Function Test Eosinophilic Level 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 (if atopic comorbidities) : _____ Test Date: _____

Pulmonary Function Test Results:
 Pre-bronchodilator FEV1: _____ Test Date: _____
 FeNO levels (if applicable): _____ Test Date: _____

Prior Failed Treatments:

Biologics _____
 ICS _____
 ICS + LABA _____
 LABA _____
 Nebulizer _____
 Oral Corticosteroids _____
 Other _____

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: _____

Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) in patients ≥18 years old

Diagnosed by: Rhinoscopy Nasal endoscopy CT Scan
 Documentation of Ongoing Symptoms?
 Nasal Obstruction or Discharge Facial Pain or Pressure
 Reduction in or Loss of Smell N/A

Results and date of last CT scan or endoscopy, including polyp location/catheterization, if applicable: _____ Test Date: _____

History of Nasal Surgeries and Procedures? Yes No
 Endoscopic Polyp Removal (Polypectomy)
 Functional Endoscopic Sinus Surgery (FESS)
 Other: _____

If no, reason(s) patient may not be a candidate for surgery: _____

Prior Failed Treatments:

Oral Corticosteroids _____
 Intranasal Corticosteroids _____
 Medicated or Saline Nasal Rinse _____
 Surgery _____
 Other _____

Indicate Drug Name and Length of Treatment:

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

4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PRODUCT DELIVERY: Patient's Home 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
<input type="checkbox"/> DUPIXENT®	<input type="checkbox"/> 200mg/1.14ml Prefilled Syringe	For adults and adolescents 12 years of age and older: <input type="checkbox"/> Induction Dose: Inject 400mg SC on day one <input type="checkbox"/> Maintenance: Inject 200mg SC every other week	2	0
	<input type="checkbox"/> 300mg/2ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 600mg SC on day one <input type="checkbox"/> Maintenance: Inject 300mg SC every other week	2	0
	<input type="checkbox"/> 300mg/2ml Prefilled Pen	For adults with chronic rhinosinusitis with nasal polyposis: <input type="checkbox"/> Inject 300mg SC every other week	2	
<input type="checkbox"/> _____				

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.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.

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Diagnosed by: Pulmonary Function Test Eosinophilic Level Assessment: Moderate Moderate to Severe Severe

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 IgE Level (if atopic comorbidities): _____ Test Date: _____

Pulmonary Function Test Results:
 Pre-bronchodilator FEV1: _____ Test Date: _____
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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
<input type="checkbox"/> XOLAIR®	<input type="checkbox"/> 75mg/0.5ml Prefilled Syringe <input type="checkbox"/> 150mg/1ml Prefilled Syringe <input type="checkbox"/> 150mg/1.2ml Lyophilized Powder Vial	<input type="checkbox"/> Inject 75mg SC every 4 weeks <input type="checkbox"/> Inject 150mg SC every 4 weeks <input type="checkbox"/> Inject 225mg SC every 2 weeks <input type="checkbox"/> Inject 225mg SC every 4 weeks <input type="checkbox"/> Inject 300mg SC every 2 weeks <input type="checkbox"/> Inject 300mg SC every 4 weeks <input type="checkbox"/> Inject 375mg SC every 2 weeks <input type="checkbox"/> Other: _____		
<input type="checkbox"/>				

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

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