

Phone: 800.511.5144 • Fax: 877.541.1503

PEDIATRIC ASTHMA REFERRAL FORM

PATIENT INFORMATION			
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:	
Address:		City:	State: Zip:
Emergency Contact:		Phone:	<input type="checkbox"/> Please attach demographic information
PRESCRIBER INFORMATION			
Prescriber:		NPI:	DEA: State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State: Zip:
Phone:	Fax:	Key Office Contact:	Phone:
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT			
<input type="checkbox"/> J82 Pulmonary Eosinophilia <input type="checkbox"/> J45.40 Moderate Persistent Asthma, uncomplicated <input type="checkbox"/> J45.50 Severe Persistent Asthma, uncomplicated <input type="checkbox"/> Other ICD10: _____ FEV1: _____% Pre-treatment serum IgE: <input type="checkbox"/> <30 IU/mL <input type="checkbox"/> ≥30-100 IU/mL <input type="checkbox"/> >100-200 IU/mL <input type="checkbox"/> >200-300 IU/mL <input type="checkbox"/> >300-400 IU/mL <input type="checkbox"/> >400-500 IU/mL <input type="checkbox"/> >500-600 IU/mL <input type="checkbox"/> >600-700 IU/mL Patient's medical history includes: <input type="checkbox"/> Positive RAST <input type="checkbox"/> Positive skin test to perennial aeroallergen <input type="checkbox"/> Asthma with eosinophilic phenotype <input type="checkbox"/> Other _____ Current maintenance treatment (include dose and frequency): _____ Current exacerbation treatment (include dose and frequency): _____ Patient is a smoker or is exposed to smoke in the home: <input type="checkbox"/> Yes <input type="checkbox"/> No			
INSURANCE INFORMATION			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID:	
PRESCRIPTION INFORMATION			
<input type="checkbox"/> Dupixent (Dupilumab) 200 mg / 1.14 mL Prefilled Syringe <input type="checkbox"/> New start <input type="checkbox"/> Existing therapy <input type="checkbox"/> Starter Dose: Inj. 400 mg (2 syringes) SQ on Day 1, then 200 mg (1 syringe) SQ every other week starting on Day 15 <input type="checkbox"/> Maintenance Dose: Inj. 200 mg (1 syringe) SQ every 2 weeks		QTY: _____	Refills: <u>0</u>
<input type="checkbox"/> Dupixent (Dupilumab) 300 mg / 2 mL Prefilled Syringe <input type="checkbox"/> New start <input type="checkbox"/> Existing therapy <input type="checkbox"/> Starter Dose: Inj. 600 mg (2 syringes) SQ on Day 1, then 300 mg (1 syringe) SQ every 2 weeks starting on Day 15 <input type="checkbox"/> Maintenance Dose: Inj. 300 mg (1 syringe) SQ every 2 weeks		QTY: <u>2</u>	Refills: <u>0</u>
<input type="checkbox"/> Fasena® (Benralizumab) 30 mg/mL Prefilled Syringe (OR) <input type="checkbox"/> Pen <input type="checkbox"/> New start <input type="checkbox"/> Existing therapy <input type="checkbox"/> Starter Dose: Administer 30 mg SQ every 4 weeks for 3 doses <input type="checkbox"/> Starter Dose not needed. <input type="checkbox"/> Maintenance Dose: Administer 30 mg SQ every 8 weeks		QTY: <u>1 box (1 pen/syringe)</u>	Refills: <u>2</u>
<input type="checkbox"/> Xolair® (Omalizumab) 150 mg <input type="checkbox"/> Vial (OR) <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 225 mg SQ every 2 weeks <input type="checkbox"/> 300 mg SQ every 2 weeks <input type="checkbox"/> 375 mg SQ every 2 weeks <input type="checkbox"/> 75 mg SQ every 4 weeks (OR) <input type="checkbox"/> 75 mg Pre-filled Syringe <input type="checkbox"/> 150 mg SQ every 4 weeks <input type="checkbox"/> 225 mg SQ every 4 weeks <input type="checkbox"/> 300 mg SQ every 4 weeks <input type="checkbox"/> 375 mg SQ every 4 weeks		QTY: <u>1 month</u>	Refills: _____
<input type="checkbox"/> Diluent (sterile water) 10 mL Vial – Use to reconstitute medication		QTY: <u>QS 1 month</u>	Refills: _____
<input type="checkbox"/> Syringe 18 g 1 inch (to mix) <input type="checkbox"/> Needle 25 g (to inj.)		QTY: <u>QS 1 month</u>	Refills: _____

I authorize AcariaHealth to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at any time in writing by sending a letter to AcariaHealth 6923 Lee Vista Blvd, Suite 300 Orlando, FL 32822. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. A copy of this authorization will be utilized with the same effectiveness as the original.

Patient Signature (required for participation) _____ Date _____

Prescriber's Signature: _____ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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