

Date Shipment Needed: _____ Ship To: Patient Prescriber
 Nursing needed; Training needed ► All the supplies including syringes and needles will be dispensed if needed.

Phone: 800.511.5144 • Fax: 877.541.1503

A-N 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 ASSESMENT			
<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"/> STC Standard Protocol will include the following: (1) dispensing ordered med/dose, (2) diluent mix and / or dilute dose. (3) Normal Saline flushes and extra Normal Saline 10ml to flush line and anakit med(epinephrine 0.3mg IM/0.15mg IM (for pediatric patients) and diphenhydramine 50mg/mL) pm.			
<input type="checkbox"/> Cinqair IV (Reslizumab) <input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required Inject 3mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes • IV administration/infusion set (0.2micron filter)			
<input type="checkbox"/> Dupixent® (Dupilumab) 200 mg/1.14 mL <input type="checkbox"/> Prefilled Syringe (2/pkg) <input type="checkbox"/> Pen <input type="checkbox"/> New start <input type="checkbox"/> Existing therapy <input type="checkbox"/> Starter Dose: Inj. 400 mg (2 syringes/pens) SQ on Day 1, then 200 mg (1 syringe/pen) SQ every other Week starting on Day 15 <input type="checkbox"/> Starter Dose not needed. <input type="checkbox"/> Maintenance Dose: Inj. 200 mg (1 syringe/pen) SQ every 2 Weeks		QTY: _____	Refills: _____
<input type="checkbox"/> Dupixent (Dupilumab) 300 mg/2 mL <input type="checkbox"/> Prefilled Syringe (2/pkg) <input type="checkbox"/> Pen <input type="checkbox"/> New start <input type="checkbox"/> Existing therapy <input type="checkbox"/> Starter Dose: Inj. 600 mg (2 syringes/pens) SQ on Day 1, then 300 mg (1 syringe/pen) SQ every 2 Weeks starting on day 15 <input type="checkbox"/> Starter Dose not needed. <input type="checkbox"/> Maintenance Dose: Inj. 300 mg (1 syringe/pen) SQ every 2 Weeks		QTY: <u> 2 </u>	Refills: <u> 0 </u>
<input type="checkbox"/> Fasenra® (Benralizumab) 30 mg/mL <input type="checkbox"/> Prefilled Syringe <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"/> Nucala (Mepolizumab) 100 mg Vial <input type="checkbox"/> 100 mg SQ every 4 weeks <input type="checkbox"/> Diluent (sterile water) 10 mL Vial – Use to reconstitute medication <input type="checkbox"/> Syringe 18 g 1 inch (to mix) <input type="checkbox"/> Needle 25 g (to inj.)		QTY: <u> 1 month </u>	Refills: _____
<input type="checkbox"/> Nucala (Mepolizumab) 100 mg/mL <input type="checkbox"/> Autoinjector (OR) <input type="checkbox"/> Pre-filled Syringe 100 mg SQ every 4 weeks		QTY: <u> 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.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.