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

PEDIATRIC ASTHMA REFERRAL FORM

Phone: 800.511.5144 • Fax: 877.541.1503

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐M ☐F	Weight:	☐lbs. ☐kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐**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

☐J82 Pulmonary Eosinophilia ☐J45.40 Moderate Persistent Asthma, uncomplicated ☐J45.50 Severe Persistent Asthma, uncomplicated ☐Other ICD10:_____

FEV1: _____% Pre-treatment serum IgE: ☐<30 IU/mL ☐≥30-100 IU/mL ☐>100-200 IU/mL ☐>200-300 IU/mL ☐>300-400 IU/mL ☐>400-500 IU/mL ☐>500-600 IU/mL ☐>600-700 IU/mL

Patient's medical history includes: ☐Positive RAST ☐Positive skin test to perennial aeroallergen ☐Asthma with eosinophilic phenotype ☐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: ☐Yes ☐No

INSURANCE INFORMATION

☐**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐**Please check if enrolling in copay card** **Copay ID:**

PRESCRIPTION INFORMATION

☐**Dupixent (Dupilumab) 200 mg / 1.14 mL ☐Prefilled Syringe ☐ Pen (for pts >2yrs old)** ☐New start ☐Existing therapy

☐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 QTY: 2 Refills: 0

☐Maintenance Dose: Inj. 200 mg (1 syringe/pen) SQ every 2 weeks QTY: 2 Refills: _____

☐**Dupixent (Dupilumab) 300 mg / 2 mL ☐Prefilled Syringe ☐ Pen (for pts >2 yrs old)** ☐New start ☐Existing therapy

☐Starter Dose: Inj. 600 mg (2 syringes/pen) SQ on Day 1, then 300 mg (1 syringe/pen) SQ every 2 weeks starting on Day 15 QTY: 2 Refills: 0

☐Maintenance Dose: Inj. 300 mg (1 syringe/pen) SQ every 2 weeks QTY: 2 Refills: _____

☐**Fasenra® (Benralizumab) 30 mg/mL Prefilled Syringe (OR) ☐ Pen** ☐New start ☐Existing therapy

☐Starter Dose: Administer 30 mg SQ every 4 weeks for 3 doses QTY: 1 box (1 pen/syringe) Refills: 2

☐Starter Dose not needed.

☐Maintenance Dose: Administer 30 mg SQ every 8 weeks QTY: 1 box (1 pen/syringe) Refills: _____

☐**Tezspire (Tezepelumab-ekko)**

☐ 210mg Pen ☐ 210mg PFS QTY: 1 month Refills: _____

Inject 210mg SQ once every 4 weeks

☐**Xolair® (Omalizumab) 75mg and/or 150 mg ☐Vial (see below for supplies) ☐Pre-filled Syringe**

☐225 mg SQ every 2 weeks QTY: QS/month Refills: _____

☐300 mg SQ every 2 weeks

☐375 mg SQ every 2 weeks

☐75 mg SQ every 4 weeks

☐150 mg SQ every 4 weeks

☐225 mg SQ every 4 weeks

☐300 mg SQ every 4 weeks

☐375 mg SQ every 4 weeks

☐Diluent (sterile water) 10 mL Vial – Use to reconstitute medication QTY: QS 1 month Refills: _____

☐Syringe 18 g 1 inch (to mix) ☐Needle 25 g (to inj.) QTY: QS 1 month 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.

Rev: 20230323