For assistance, contact your pharmacy representative: _____ Phone:_____ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens + PRIME

Asthma

Prescription/Pharmacy Intake Form

Pharmacy: _____

Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB:_____ ☐Male ☐Female

Address: _____

City: _____State: _____ Zip code:_____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address:_____ Case Manager: _____

Insurance provider **(Please include copy of front and back of card)**: _____

ID #:_____Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured:_____ Employer: _____

Relationship to Patient: ☐Self ☐Other:_____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

Will there be access to anaphylactic medications and oxygen at the administration site? _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: _____

Diagnosis: ☐Moderate persistent asthma, uncomplicated (J45.40) ☐Severe persistent asthma, uncomplicated (J45.50) ☐Eosinophilic granulomatosis with polyangiitis (M30.1)

☐Pulmonary eosinophilia, not elsewhere classified (J82) ☐Other_____ Date of Diagnosis: _____

Other Diagnosis/Conditions: _____

Eosinophil count _____ Cells/µL IgE Level_____ IU/mL Current Weight:_____ ☐lb ☐kg Date: _____ Current Height: _____ ☐in ☐cm Date: _____

☐Other Therapies Tried & Failed (Please List): _____

Allergies: _____

PRESCRIPTION INFORMATION

☐**Cinqair (reslizumab) 100 mg/10 mL vial**
Directions: 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes. To be administered by a healthcare professional.
Quantity:_____ Refills: _____

☐**Dupixent (dupilumab)**
☐200 mg/1.14 mL pre-filled syringe
Initial dose of 400 mg (two 200 mg injections at different injection sites) followed by 200 mg given every other week into the thigh or abdomen by subcutaneous injection.
☐300 mg/2 mL pre-filled syringe
Initial dose of 600 mg (two 300 mg injections at different injection sites) followed by 300 mg given every other week into the thigh or abdomen by subcutaneous injection.
Quantity:_____ Refills: _____

☐**Nucala (mepolizumab)**
SEVERE ASTHMA
☐100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen. To be administered by a healthcare professional.
☐100 mg/mL solution in a single-dose pre-filled auto-injector (NDC 0173-0892-01) Directions:100 mg subcutaneous to upper arm, thigh or abdomen every 4 weeks.
☐100 mg/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42) Directions:100 mg subcutaneous to upper arm, thigh or abdomen every 4 weeks.
EOSINOPHILIC GRANULOMATOSIS WITH POLYAGNIITIS (EGPA)
☐300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh or abdomen. To be administered by a healthcare professional.
☐300 mg as 3 separate 100 mg/mL solution in a single-dose pre-filled auto-injector (NDC 0173-0892-01) Directions:100 mg subcutaneous to upper arm, thigh or abdomen every 4 weeks.
☐300 mg as 3 separate 100 mg/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42) Directions:100 mg subcutaneous to upper arm, thigh or abdomen every 4 weeks.
☐ Quantity: _____ Refills: _____

☐**Fasenra (benralizumab) 30 mg/mL pre-filled syringe**
Directions: 30 mg/mL into the upper arm, thigh or abdomen by subcutaneous injection every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter. To be administered by a healthcare professional.
Quantity: _____ Refills: _____

☐**Xolair (omalizumab) 150 mg vial kit**
☐Supply Kit
(#2) 18g 1 & ½ syringe 3ml
(#2) 25g 5/8 safety needle
(#2) alcohol swabs

☐**Xolair PFS (omalizumab) 75 mg/0.5 mL pre-filled syringe**

☐**Xolair PFS (omalizumab) 150 mg/1 mL pre-filled syringe**
Directions:
Every 4 weeks dosing:
☐75 mg per dose subcutaneously every 4 weeks. To be administered by a healthcare professional.
☐150 mg per dose subcutaneously every 4 weeks. To be administered by a healthcare professional.
☐225 mg per dose subcutaneously every 4 weeks. To be administered by a healthcare professional.
☐300 mg per dose subcutaneously every 4 weeks. To be administered by a healthcare professional.
Every 2 weeks dosing:
☐225 mg per dose subcutaneously every 2 weeks. To be administered by a healthcare professional.
☐300 mg per dose subcutaneously every 2 weeks. To be administered by a healthcare professional.
☐375 mg per dose subcutaneously every 2 weeks. To be administered by a healthcare professional.
Quantity: _____ Refills: _____

☐**Other:** _____
Directions: _____
Quantity: _____ Refills: _____

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name:_____ Practice/facility:_____

Address: _____ City: _____ State: _____Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #:_____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date