meijer specialty pharmacy

P: 1-855-263-4537 • F: 734-391-2365
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# Allergy/Immunology

## Physician Information

Send updates to: ◯ Fax: _____ ◯ Email: _____ ◯ Text: _____

| | | | |
|---|---|---|---|
| Prescriber Name: | | ◯MD ◯DO ◯NP ◯PA | NPI: |
| Office Contact: | | Practice Name / Supervising MD: | |
| Address: | | City: | |
| State: | Zip: | Phone: | Fax: |

## Patient Information | PLEASE SEND COPY OF INSURANCE CARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Patient's Name: | Last 4 Digits of SS#: | DOB: / / | Sex: ◯ M ◯ F | Weight: | Height: | Diabetic: ◯ Y ◯ N |
| Address: | City: | State: | Zip: | Allergies: | | |
| Home Phone: | Work Or Cell: | HIPAA Contact: | Emergency #: | Interpreter Needed? ◯ Y ◯ N | | |

## Insurance Information

| | | | |
|---|---|---|---|
| Primary Insurance: | Policy ID: | Group #: | |
| Policyholder Name: | Policyholder DOB: | BIN: | PCN: |

## Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

**ICD-10/Diagnosis Code:** ◯ Pulmonary Eosinophilia (J82) ◯ Moderate Persistent Asthma, uncomplicated (J45.40) ◯ Severe Persistent Asthma, uncomplicated (J45.50) ◯ Idiopathic Urticaria (L50.1)

◯ Atopic Dermatitis (L20.9) ◯ Other:

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 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: ◯ Y ◯ N

Prior Treatment? ◯ Y ◯ N (Provide Information Below) BSA affected (%): Affected Areas: ◯ Palms ◯ Soles ◯ Head ◯ Neck ◯ Genitalia ◯ Other:

| Prior Therapy | Reason for Discontinuation of Therapy | Approximate Start Date | Approximate End Date |
|---|---|---|---|
| | | | |

Comorbidities: Concomitant Medications:

## Prescription Information

| Medication | Quantity/Dose | Sig | Refills |
|---|---|---|---|
| ◯ **DUPIXENT®** | ◯ 1 carton (2x200mg/1.14mL)<br>◯ 1 carton (2x300mg/2ml) | **Starter Dose:**<br>◯ Inject 400mg SQ at week 0. Begin Maintenance Dose at week 2<br>◯ Inject 600mg SQ at week 0. Begin Maintenance Dose at week 2 | No Refills |
| | | **Maintenance Dose:**<br>◯ Inject 200mg every 2 weeks<br>◯ Inject 300mg every 2 weeks | |
| ◯ **XOLAIR®** | ◯ Number of 150mg/5ml vials: _____ | ◯ Inject _____mg SQ once every _____ weeks | |
| ◯ **Sterile Water For Injection** | ◯ Number of vials: _____ | ◯ Use with Xolair as directed | |
| ◯ Other: | | | |

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

| Physician Signature: | Date |
|---|---|
| | |

Substitution Permitted

| Physician Signature: | Date |
|---|---|
| | |

Dispense as Written