

Ship Meds to:  Patient's Home  Prescriber's Office

**Prescriber Information**

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> 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: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:		City:	State:	Zip:	Allergies:	
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:		Interpreter Needed? <input type="radio"/> Y <input type="radio"/> 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:	<input type="radio"/> Pulmonary Eosinophilia (J82) <input type="radio"/> Moderate Persistent Asthma, uncomplicated (J45.40) <input type="radio"/> Severe Persistent Asthma, uncomplicated (J45.50) <input type="radio"/> Idiopathic Urticaria (L50.1)				
<input type="radio"/> Atopic Dermatitis (L20.9) <input type="radio"/> Nasal Polyp (J33.____) <input type="radio"/> Other:					
FEV1: %	Pre-treatment serum IgE: <input type="radio"/> <30 IU/mL <input type="radio"/> ≥30-100 IU/mL <input type="radio"/> >100-200 IU/mL <input type="radio"/> >200-300 IU/mL <input type="radio"/> >300-400 IU/mL <input type="radio"/> >400-500 IU/mL <input type="radio"/> >500-600 IU/mL <input type="radio"/> >600-700 IU/mL				
Patient medical history includes: <input type="radio"/> Positive RAST <input type="radio"/> Positive skin test to perennial aeroallergen <input type="radio"/> Asthma with eosinophilic phenotype <input type="radio"/> 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="radio"/> Y <input type="radio"/> N
Prior Treatment? <input type="radio"/> Y <input type="radio"/> N (Provide Information Below)		BSA affected (%):	Affected Areas: <input type="radio"/> Palms <input type="radio"/> Soles <input type="radio"/> Head <input type="radio"/> Neck <input type="radio"/> Genitalia <input type="radio"/> Other:		
Prior Therapy	Reason for Discontinuation of Therapy		Approx Start Date	Approx End Date	
Comorbidities:			Concomitant Medications:		

**Prescription Information**

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> <b>DUPIXENT®</b> *Asthma	<input type="radio"/> 1 carton (2x200mg/1.14mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PEN	<b>Starter Dose:</b> <input type="radio"/> Inject 400mg SQ at week 0. Begin Maintenance Dose at week 2 <input type="radio"/> Inject 600mg SQ at week 0. Begin Maintenance Dose at week 2  <b>Maintenance Dose:</b> <input type="radio"/> Inject 200mg every 2 weeks <input type="radio"/> Inject 300mg every 2 weeks	No Refills
	<input type="radio"/> 1 carton (2x300mg/2mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PEN	<input type="radio"/> Inject 300mg SQ every 2 weeks.	
<input type="radio"/> <b>DUPIXENT®</b> *Pediatrics (age 6 & older) – Atopic Dermatitis Only	<input type="radio"/> 1 carton (2x200mg/1.14mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PEN <i>*Dupixent pens only for use in adolescents aged 12 or older</i>	<b>Starter Dose:</b> <input type="radio"/> <b>Weight 15-29kg:</b> Inject 600mg SQ at week 0. Begin maintenance dose at week 4 <input type="radio"/> <b>Weight 30-59kg:</b> Inject 400mg SQ at week 0. Begin maintenance dose at week 2 <input type="radio"/> <b>Weight ≥ 60kg:</b> Inject 600mg SQ at week 0. Begin maintenance dose at week 2	No Refills
	<input type="radio"/> 1 carton (2x200mg/1.14mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PEN <i>*Dupixent pens only for use in adolescents aged 12 or older</i>	<b>Maintenance Dose:</b> <input type="radio"/> <b>Weight 15-29kg:</b> Inject 300mg SQ every 4 weeks <input type="radio"/> <b>Weight 30-59kg:</b> Inject 200mg SQ every 2 weeks <input type="radio"/> <b>Weight ≥ 60kg:</b> Inject 300mg SQ every 2 weeks	
<input type="radio"/> <b>FASENRA®</b>	<input type="radio"/> 1 carton (30mg/mL) PFS <input type="radio"/> 1 carton (30mg/mL) PEN	<b>Starter Dose:</b> <input type="radio"/> Inject 30mg SQ every 4 weeks for the first 3 doses	2
	<input type="radio"/> 1 carton (30mg/mL) PFS <input type="radio"/> 1 carton (30mg/mL) PEN	<b>Maintenance Dose:</b> <input type="radio"/> Inject 30mg SQ every 8 weeks	

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.

Prescriber Signature:	Date	Prescriber Signature:	Date
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Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.