Kroger specialty pharmacy

Immunology

New Orleans, LA **toll free** **toll free fax** **krogerspecialtypharmacy.com**

Need By Date: ______________________ Ship To: ☐ Patient ☐ Office Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Male ☐ Female

Prescriber Information

Prescriber Name		
Address		
City State Zip		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ J45.40 Moderate Asthma ☐ J45.50 Severe Asthma ☐ L20.9 Atopic Dermatitis ☐ L50.1 Chronic Idiopathic Urticaria (CIU) ☐ J33 Chronic Rhinosinusitis with Nasal Polyposis ☐ Other: ______________ Dx Code: ________

Eosinophil Levels

Concomitant Therapies: ☐ Short-acting Beta Agonist ☐ Long-acting Beta Agonist ☐ Antihistamines ☐ Decongestants ☐ Immunotherapy ☐ Inhaled Corticosteroid ☐ Leukotriene Modifiers ☐ Oral Steroids ☐ Nasal Steroids ☐ Other: ______________

Please List Therapies

Weight ☐ kg ☐ lbs

Date Weight Obtained

Lab Results: ☐ History of positive skin OR RAST test to a perennial aeroallergen

Pretreatment Serum IgE Level: ______________ IU per mL Test Date: ______ / ______ / ______

MD Specialty: ☐ Allergist ☐ Dermatologist ☐ ENT ☐ Pediatrician ☐ Primary Care ☐ Pulmonologist ☐ Other: ______________

Prescription Type: ☐ Naïve/New Start ☐ Restart ☐ Continued Therapy

Last Injection Date: ______ / ______ / ______

Drug Allergies

Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

Prescription Information			Qty	Refills
☐ Dupixent®	200mg ☐ Pen ☐ PFS w/Shield ☐ Asthma ☐ Atopic Dermatitis	☐ Load: Inject 400mg (as two-200mg injections in different sites) on day 1, then inject 200mg every other week starting on day 15 ☐ Maintenance: Inject 200mg subcutaneously every other week	2 Syringes 2 Syringes	None ________
	300mg ☐ Pen ☐ PFS w/Shield ☐ Asthma ☐ Atopic Dermatitis	☐ Load: Inject 600mg (as two-300mg injections in different sites) on day 1, then inject 300mg every other week starting on day 15 ☐ Maintenance: Inject 300mg subcutaneously every other week	2 Syringes 2 Syringes	None ________
	300mg ☐ Pen ☐ PFS w/Shield ☐ Chronic Rhinosinusitis with Nasal Polyposis	Inject 300mg subcutaneously every other week	2 Syringes	________
☐ Fasenra®		Fax completed Fasenra Access 360™ Enrollment Form to Kroger Specialty Pharmacy at 844.306.0200		
☐ Nucala®	☐ 100mg Pre-filled Auto-injector ☐ 100mg PFS ☐ 100mg Vial* **Supplies dispensed: One 10mL vial sterile water for injection for every Nucala vial dispensed, alcohol swabs, 3mL Luer Lock inj syringe, 21G NDL for reconstitution, 1mL polypropylene syringe with 21G to 27G x 1/2" NDL for subcutaneous injection* *☐ No supplies requested (supplies will be sent with shipment unless indicated)*	☐ **Patients with Asthma** Inject 100mg subcutaneously once every 4 weeks ☐ **Patients with EGPA** Inject 300mg (3-100mg injections) subcutaneously once every 4 weeks	28 Day Supply 28 Day Supply	________ ________
☐ Xolair®	75mg ☐ PFS ☐ Autoinjector 150mg ☐ PFS ☐ Autoinjector ☐ Vial* 300mg ☐ PFS ☐ Autoinjector **Supplies dispensed: One 10mL sterile water for injection for every Xolair vial dispensed, alcohol swabs, 3mL Luer Lock inj syringe, 18G x 1 1/2" Safety Glide NDL for reconstitution, 25G x 5/8" Safety Glide NDL for subcutaneous injection* *☐ No supplies requested (supplies will be sent with shipment unless indicated)*	**Patients with Asthma** ☐ Inject 75mg subcutaneously once every 4 weeks ☐ Inject 150mg subcutaneously once every 4 weeks ☐ Inject 225mg subcutaneously once every 2 weeks ☐ Inject 225mg subcutaneously once every 4 weeks ☐ Inject 300mg subcutaneously once every 2 weeks ☐ Inject 300mg subcutaneously once every 4 weeks ☐ Inject 375mg subcutaneously once every 2 weeks **Patients with CIU** ☐ Inject 150mg subcutaneously once every 4 weeks ☐ Inject 300mg subcutaneously once every 4 weeks	28 Day Supply	________
☐ EpiPen® *(Injection)*	0.3mg/0.3mL Pre-filled Auto-injector	Inject EpiPen® 0.3mg intramuscularly or subcutaneously in patients greater than or equal to 30kg (66lbs)	2	0
☐ EpiPen®**Jr** *(Injection)*	0.15mg/0.3mL Pre-filled Auto-injector	Inject EpiPen®**Jr** 0.15mg intramuscularly or subcutaneously in patients 15 to 30kg (33lbs to 66lbs)	2	0
☐ Other				

By signing this form, you are authorizing Kroger® Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. 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 in error and then destroy this document immediately.

Prescriber's Signature (no stamps) Substitution Permitted ______ Date ______

Prescriber's Signature (no stamps) Dispense As Written ______ Date ______