



SPECIALTY PHARMACY

# PULMONOLOGY

Orlando, FL toll free 855.274.1694 toll free fax 844.306.0200

[krogerspecialtypharmacy.com](http://krogerspecialtypharmacy.com)

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO:  OFFICE \_\_\_\_\_

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

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

PLEASE FAX COPY OF:  PRESCRIPTION CARD FRONT & BACK  CLINICAL NOTES  MEDICAL CARD FRONT & BACK

## CLINICAL INFORMATION

Diagnosis:  J45.40 Moderate Asthma  J45.50 Severe Asthma  J45.901 Allergic Asthma  
 Other: Dx code \_\_\_\_\_ Condition \_\_\_\_\_ Eosinophil levels: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_  
 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: \_\_\_\_\_  
 Lab results:  History of positive skin OR RAST test to a perennial aeroallergen  
 Pretreatment serum IgE level \_\_\_\_\_ IU per mL Test date \_\_\_\_\_ Patient weight \_\_\_\_\_ kg Date weight obtained \_\_\_\_\_  
 MD Specialty:  Pulmonologist \_\_\_\_\_  
 Prescription type:  Naive/new start  Restart  Continued Therapy Last injection date: \_\_\_\_\_

		PRESCRIPTION INFORMATION	QUANTITY	REFILLS
<input type="checkbox"/> Dupixent*		Please complete Dupixent MyWay™ Enrollment Form and fax to Kroger SP at 844.306.0200.		
<input type="checkbox"/> Esbriet*	<input type="checkbox"/> 267mg Capsules <input type="checkbox"/> 267mg Tablets <input type="checkbox"/> 801mg Tablets	<input type="checkbox"/> Initial 14 day Titration: Days 1 - 7: 267mg three times daily (801mg/day) Days 8 - 14: 534mg three times daily (1602mg/day) Days 15+: 801mg three times daily (2403mg/day) <input type="checkbox"/> Take orally 801mg three times daily (2403 mg/day) with food		
<input type="checkbox"/> Fasenra™		Please complete Fasenra Access 360™ Enrollment Form and fax to Kroger SP at 844.306.0200.		
<input type="checkbox"/> Nucala*	Diluent: 1.2mL of sterile water for Injection, USP, preferably using a 2 or 3mL syringe and a 21-gauge needle. The reconstituted solution will contain a concentration of 100mg/mL mepolizumab.	<input type="checkbox"/> Patients with Asthma - Inject 100mg subcutaneously once every 4 weeks <input type="checkbox"/> Patients with EGPA - Inject 300mg (3-100mg injections) subcutaneously once every 4 weeks	28 day supply  28 day supply	_____  _____
<input type="checkbox"/> Xolair* (Patients with Allergic Asthma)	Diluent: 10mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3mL syringes as needed for reconstitution; 25-gauge needles as needed for administration.	<input type="checkbox"/> Inject 75mg subcutaneously once every 4 weeks <input type="checkbox"/> Inject 150mg subcutaneously once every 4 weeks <input type="checkbox"/> Inject 225mg subcutaneously once every 2 weeks <input type="checkbox"/> Inject 225mg subcutaneously once every 4 weeks <input type="checkbox"/> Inject 300mg subcutaneously once every 2 weeks <input type="checkbox"/> Inject 300mg subcutaneously once every 4 weeks <input type="checkbox"/> Inject 375mg subcutaneously once every 2 weeks	28 day supply	_____
<input type="checkbox"/> 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
<input type="checkbox"/> 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
<input type="checkbox"/> Other				

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

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

**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.

05437 02-04-2019 OFL