IMMUNOLOGY

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ OFFICE ❑ PATIENT ❑

PATIENT INFORMATION

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

PRESCRIBER INFORMATION

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 ❑ L20.9 Atopic Dermatitis ❑ L50.1 Chronic Idiopathic Urticaria (CIU)
❑ J33 Chronic Rhinosinusitis with Nasal Polyposis ❑ Other: Dx code _____ Condition _____
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: _____ Eosinophil Levels: _____ Patient Weight: _____ kg Date Weight Obtained: _____
MD Specialty: ❑ Allergist ❑ Pulmonologist ❑ ENT ❑ Primary Care ❑ Pediatrician ❑ Dermatologist ❑ Other: _____
Prescription Type: ❑ Naïve/New Start ❑ Restart ❑ Continued Therapy Last Injection Date: _____

PRESCRIPTION INFORMATION

			QUANTITY	REFILLS
❑ Dupixent®	200mg PFS w/shield ❑ Asthma ❑ Atopic Dermatitis	❑ Load: Inject 400mg subcutaneously (2-200mg syringes in different injection sites) on Day 1, then 200mg on Day 15, then 200mg every other week ❑ Maintenance: Inject 200mg subcutaneously every other week	2 syringes 2 syringes	None _____
	300mg PFS w/shield ❑ Asthma ❑ Atopic Dermatitis	❑ Load: Inject 600mg subcutaneously (2-300mg syringes in different injection sites) on Day 1, then 300mg on Day 15, then 300mg every other week ❑ Maintenance: Inject 300mg subcutaneously every other week	2 syringes 2 syringes	None _____
	300mg PFS w/shield ❑ Chronic Rhinosinusitis with Nasal Polyposis	Inject 300mg subcutaneously every other week	2 syringes	_____
❑ Fasenra®		Fax completed Fasenra Access 360TM Enrollment Form to KSP at 844.306.0200		
❑ Nucala®	❑ 100mg pre-filled auto-injector ❑ 100mg PFS ❑ 100mg Vial* **supplies dispensed: One 10mL vial sterile water for inj 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 inj* ❑ *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) subcutaneously once every 4 weeks	28 day supply 28 day supply	_____ _____
❑ Xolair®	❑ 75mg PFS ❑ 150mg PFS ❑ 150mg Vial* **supplies dispensed: One 10mL sterile water for inj 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 inj* ❑ *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 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