Asthma/Allergy Enrollment Form (A-E)

PYRAMIDS PHARMACY WEBSTER

www.pyramidspharmacy.com

All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

- ❑ J45.4 Moderate Persistent Asthma
- ❑ J45.5 Severe Persistent Asthma
- ❑ L20.9 Atopic Dermatitis
- ❑ M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA)
- ❑ Other: _____

MD Specialty:

- ❑ Allergist ❑ Primary Care
- ❑ Pulmonologist ❑ ENT
- ❑ Pediatrician ❑ Other: _____

Prescription type:

- ❑ New start
- ❑ Restart
- ❑ Continuation

Prior anaphylactic reaction: ❑ Yes ❑ No

Reason and date: _____

Concomitant therapies:

- ❑ Short-acting beta agonist: _____
- ❑ Long-acting beta agonist: _____
- ❑ Inhaled corticosteroids: _____
- ❑ Oral steroids: _____
- ❑ Leukotriene modifiers: _____
- ❑ Antihistamines: _____
- ❑ Nasal steroids: _____
- ❑ Other: _____

Previously tried/failed therapies and reason for discontinuation: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Auvi-Q®	❑ 0.15 mg Autoinjector **(Patients 15-30 kg)** ❑ 0.3 mg Autoinjector **(Patients ≥ 30 kg)**	❑ Inject one autoinjector IM or subQ into outer thigh, through clothing if necessary.		
❑ Cinqair®	❑ 100 mg/10 mL *Patient Dosing Wt: _____kg*	❑ Administer _____ mg (3mg/kg) IV infusion over 20 to 50 minutes once every 4 weeks.		
❑ Dupixent®	❑ 200 mg Prefilled Syringe	❑ **Initial Dose**: Inject 400 mg (two 200 mg injections) subQ on Day 1, then maintenance dose starting Day 15. ❑ **Maintenance Dose**: Inject 200 mg subQ every other week.		
	❑ 300 mg Prefilled Syringe	*Alternative Dosing* ❑ **Initial Dose**: Inject 600 mg (two 300 mg injections) subQ on Day 1, then maintenance dose starting Day 15. ❑ **Maintenance Dose**: Inject 300 mg subQ every other week.		
❑ Epipen®	❑ 0.15 mg Autoinjector **(Patients 15-30 kg)** ❑ 0.3 mg Autoinjector **(Patients ≥ 30 kg)**	❑ Inject one autoinjector IM or subQ into outer thigh, through clothing if necessary.		

Deliver to: ❑Patient ❑Office ❑Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

❑Product Substitution Permitted ❑Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____

Asthma/Allergy Enrollment Form (F-Z)

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1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ J45.4 Moderate Persistent Asthma
❑ J45.5 Severe Persistent Asthma
❑ L20.9 Atopic Dermatitis
❑ M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA)
❑ Other: _____

MD Specialty:

❑ Allergist ❑ Primary Care
❑ Pulmonologist ❑ ENT
❑ Pediatrician ❑ Other: _____

Prescription type:

❑ New start
❑ Restart
❑ Continuation

Prior anaphylactic reaction: ❑ Yes ❑ No
Reason and date: _____

Concomitant therapies:

❑ Short-acting beta agonist: _____
❑ Long-acting beta agonist: _____
❑ Inhaled corticosteroids: _____
❑ Oral steroids: _____
❑ Leukotriene modifiers: _____
❑ Antihistamines: _____
❑ Nasal steroids: _____
❑ Other: _____

Previously tried/failed therapies and reason for discontinuation: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Fasenra®	❑ 30 mg Prefilled Syringe	❑ **Initial Dose**: Inject 30 mg subQ once every 4 weeks for the first 3 doses (Weeks 0, 4, and 8), followed by maintenance dose. ❑ **Maintenance Dose**: Inject 30 mg subQ every 8 weeks.		
❑ Nucala®	❑ 100 mg Vial *(lyophilized powder)*	❑ **Asthma**: Inject 100 mg subQ once every 4 weeks. ❑ **EGPA**: Inject 300 mg as 3 separate 100 mg injections subQ once every 4 weeks. *(Note: To be administered by healthcare provider)*		
	❑ Include Sterile Water and Supplies ❑ No Supplies Requested	Supplies ❑ One vial of Sterile Water for Injection for every Nucala Vial dispensed ❑ One 3mL 21G x 1" needle for reconstitution ❑ One 1mL 27G needle for subQ injection ❑ Alcohol swabs ❑ Bandages		
❑ **OTHER**: _____	❑ **Drug Strength**: _____	❑ **Directions**: _____		

Deliver to: ❑Patient ❑Office ❑Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

❑Product Substitution Permitted ❑Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____