Asthma Enrollment Form
Medications A-E
(Cinqair®, Dupixent®)

ABD Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

Fax Referral To: 207-899-0968
Address: 141 Preble St. Portland, ME 04101

Phone: 877-814-8447
NCPDP: 2008301

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: ☐ Male ☐ Female
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: ☐ _____ ☐ _____ ☐ _____ ☐ _____
State License #: _____ NPI #: _____ DEA #: _____ Address: _____
City, State, ZIP: _____ Group or Hospital: _____
Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Coram Ambulatory Infusion Site ☐ Other: _____

Diagnosis (ICD-10):

☐ J45.4 Moderate Persistent Asthma ☐ J45.5 Severe Persistent Asthma
☐ D47.5 Hyperesoninophilic Syndrome (HES) ☐ J33.9 & J32.9 Chronic Sinusitis with Nasal Polyposis (indication for dupilumab)
☐ M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA) ☐ Other Code: _____ Description _____
For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm IgE Level: _____
Eosinophil count: _____ Cells/µL Date of test: __/__/____ Number of exacerbations in the last 12 months: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cinqair (reslizumab)	100 mg/10 mL vial	Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes ☐ Include sodium chloride and supplies sufficient for medication days supply • IV administration/infusion set (0.2micron filter) • IV Cath Insyte autoguard or PIV insertion kit • Ultrasyte needle-free connector (one per vial shipped) • 30mL syringe (one per vial shipped) • 50mL 0.9% NaCl • 2 – 10mL 0.9% NaCl flush • Alcohol swabs	Quantity: _____ vials ☐ 30-day supply ☐ 90-day supply ☐ ____-day supply Refills: ☐ 1 year ☐ Other: _____
☐ Dupixent (dupilumab)	**PFS** ☐ 200 mg/1.14ml PFS ☐ 300 mg/2mL PFS **PEN** ☐ 300mg/2ml pre-filled pen *Comes in cartons of 2	**Initial Dose:** ☐ Inject 400mg SC (2-200mg injections in different injection sites) initially then 200mg SC every other week ☐ Inject 600mg SC (2-300mg injections in different injection sites) initially then 200mg SC every other week **Maintenance Dose:** ☐ Inject 200mg (one injection) SC every other week ☐ Inject 300mg (one injection) SC every other week **Chronic Sinusitis with Nasal Polyposis** ☐ Inject 300mg (one injection) SC every other week	Quantity:_____ Refills:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

X_____ X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Medications F-Z
Asthma Enrollment Form
(Fasenra®, Nucala®, Xolair®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Fasenra (benralizumab)	**PFS** ☐ 30 mg/mL pre-filled syringe **Auto-injector** ☐ 30 mg/mL Pen/Self-administered	☐ Administer 30mg/mL by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter ☐ Other: Administer _____	Quantity: ☐ 1 PFS/Pen ☐ 3 PFS/Pen Refills: ☐ 1 year ☐ Other: _____
☐ Nucala (mepolizumab)	**Vial** ☐ 100 mg vial **PEN** ☐ Auto-injector 100mg/mL auto-injector **PFS** ☐ 100mg/ml PFS	**SEVERE ASTHMA** ☐ Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen **EOSINOPHILIC GRANULOMATOSIS WITH POLYAGNIITIS (EGPA)** ☐ Inject 300 mg as 3 separate 100mg subcutaneous injections once every 4 weeks into the upper arm, thigh or abdomen **HYPEREOSINOPHILIC SYNDROME (HES)** ☐ Inject 300 mg as 3 separate 100mg subcutaneous injections once every 4 weeks into the upper arm, thigh or abdomen ☐ Include sterile water and supplies sufficient for medication days supply ☐ No supplies requested (supplies will be sent with shipment unless indicated) • One 10 mL vial sterile water for injection for every vial of Nucala® dispensed • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution • 1 mL polypropylene syringe with 21G to 27G x ½" needle for subcutaneous injection	Quantity: ☐ 30-day supply ☐ 90-day supply ☐ ____-day supply Refills: ☐ 1 year ☐ Other: _____
☐ Xolair (omalizumab)	**Vial** ☐ 150 mg vial kit **PFS** ☐ 75mg/0.5ml pre-filled syringe ☐ 150mg/1ml pre-filled syringe	**Every 4 weeks dosing:** ☐ Administer 75 mg per dose subcutaneously every 4 weeks ☐ Administer 150 mg per dose subcutaneously every 4 weeks ☐ Administer 225 mg per dose subcutaneously every 4 weeks ☐ Administer 300 mg per dose subcutaneously every 4 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 4 weeks **Every 2 weeks dosing:** ☐ Administer 225 mg per dose subcutaneously every 2 weeks ☐ Administer 300 mg per dose subcutaneously every 2 weeks ☐ Administer 375 mg per dose subcutaneously every 2 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 2 weeks **For Xolair Vials only:** ☐ Include sterile water and supplies sufficient for medication days supply ☐ No supplies requested (supplies will be sent with shipment unless indicated) • One 10 mL vial sterile water for injection for every vial of Xolair® dispensed • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL Luer Lock injection syringe • NDL 18G x 1½" Safety Glide needle for reconstitution • NDL 25G x ⅝" Safety Glide needle for subcutaneous injection	Quantity: ☐ 30-day supply ☐ 90-day supply ☐ ____-day supply Refills: ☐ 1 year ☐ Other: _____

I certify that the rationale for Xolair® therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

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Nursing Medications
Asthma Enrollment Form
(Epipen®, Epipen® Jr.)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
☐ Epipen	☐ Other: _____	Use as directed.	Quantity: 1 Refills: _____
☐ Epipen Jr.	☐ Other: _____	Use as directed.	Quantity: 1 Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

X_____ X_____

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