Asthma/Respiratory Enrollment Form

FACTOR ONE SOURCE FAST PHARMACY

Powered By: InfuCare Rx

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Website: www.FOSRXFAST.com

Louisiana Office
2400 Veterans Memorial Blvd., Suite 480
Kenner, LA 70062

PATIENT INFORMATION

Name:			
Address:			
City:	State/Zip:		
Telephone:	DOB:	M ☐ F ☐	
Language Preference:	Wt:	Ht:	

PRESCRIBER INFORMATION

Prescribing Practitioner:		NPI:	
Address:			
City		State/Zip	
Office:		DEA:	
Contact:	Phone:	Fax:	

PRIMARY INSURANCE INFORMATION

Member Name:	M ☐ F ☐	DOB:	
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	New ☐ Refill ☐	Ship by:

PRESCRIPTION

Drug		Directions	Quantity	Refills
Dupixent®	☐ 200 mg Pre-filled Syringe	☐ **Initial:** Inject 400 mg SQ (two 200 mg injections) SQ on day 1 (Quantity: 2) ☐ **Maintenance:** Inject 200 mg SQ every **other** week starting at day 15 (Quantity: 2)		
	☐ 300 mg Pre-filled Syringe	☐ **Initial:** Inject 600 mg SQ (two 300 mg injections) SQ on day 1 (Quantity: 2) ☐ **Maintenance:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2) ☐ Inject 300 mg SQ every other week (Qty: 2) ****Dosing intended for chronic rhinosinusitis with nasal polyposis (CRSwNP)****		
Fasenra®	☐ 30mg/mL pre-filled auto injector ☐ 30 mg Pre-filled Syringe	☐ **Initial:** Inject 30 mg SQ once every 4 weeks for first 3 doses ☐ **Maintenance:** Inject 30 mg SQ once every 8 weeks thereafter		
Nucala®	☐ 100mg pre-filled auto injector ☐ 100mg PFS ☐ 100mg Vial* ☐ *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 injection subcutaneously once every 4 weeks **supplies to be dispensed: One 10mL vial sterile water for injection for every vial of Nucala dispensed, alcohol swabs, 3 mL Luer lock injection syringe, NDL 21G needle for reconstitution, 1mL polypropylene syringe with 21G to 27G x ½" needle for subcutaneous injection*	28 day supply 28 day supply	
Xolair® ☐ Asthma ☐ CIU	Prefilled Syringe: ☐ 75 mg ☐ 150 mg ☐ 150 mg single dose vial	**Every 4 week dosing:** ☐ Administer 75 mg dose subcutaneously every 4 weeks ☐ Administer 150 mg dose subcutaneously every 4 weeks ☐ Administer 300 mg dose subcutaneously every 4 weeks ☐ Administer other: _____ mg dose subcutaneously every 4 weeks **Every 2 week dosing:** ☐ Administer 75 mg dose subcutaneously every 2 weeks ☐ Administer 150 mg dose subcutaneously every 2 weeks ☐ Administer 300 mg dose subcutaneously every 2 weeks ☐ Administer other: _____ mg dose subcutaneously every 2 weeks		

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ **Short acting beta-agonist (SABA):** _____	☐ (_____)	☐	_____
☐ **Inhaled corticosteroids with long-acting beta agonist (ICS/LABA) combination therapy:** _____	☐ (_____)	☐	_____
☐ **Inhaled corticosteroids (without LABA):** _____	☐ (_____)	☐	_____
☐ **Long-acting muscarinic antagonist (LAMA):** _____	☐ (_____)	☐	_____
☐ **Leukotreine receptor antagonist (LTRA):** _____	☐ (_____)	☐	_____
☐ **Oral/Injectable corticosteroids:** _____	☐ (_____)	☐	_____
☐ **Intra-nasal corticosteroids:** _____	☐ (_____)	☐	_____
☐ **Topical corticosteroids:** _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ D86.9 Sarcoidosis, unspecified
☐ J45.40 Moderate Persistent Asthma, uncomplicated
☐ J45.51 Severe Persistent Asthma w/ acute exacerbation
☐ L50.1 Chronic Idiopathic Urticaria
Date of Diagnosis: ____/____/_____
Allergies: _____

☐ J33.0 Polyp of Nasal Cavity
☐ J45.41 Moderate Persistent Asthma w/ acute exacerbation
☐ Other: _____

Patient Weight: _____

IgE Level _____ Date: ___/___/_____
Eosinophil levels:_____ cells/mcL Date: ___/___/_____
☐ Patient has had prior sinus surgery
Number of severe exacerbations past 12 months: _____
☐ Patient has moderate to severe asthma that requires add-on maintenance treatment
☐ Patient is not a candidate for surgery Rationale:_____

Injection Training: ☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ FOSRX/FAST to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature:	Date: