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# ALLERGY/ENT RX FORM

## PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ PHONE: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

\*PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS\*

## MEDICATION

- NUCALA \_\_\_\_\_ MG SQ EVERY 4 WEEKS
- CINQAIR 3MG/KG IV EVERY 4 WEEKS
- FASENRA 30MG SQ AT WEEKS 0, 4, AND 8, AND EVERY 8 WEEKS
- FASENRA 30MG SQ EVERY 8 WEEKS
- XOLAIR \_\_\_\_\_ MG SQ EVERY \_\_\_\_\_ WEEKS
- DUPIXENT 600MG SQ AT WEEK 0, 300MG SQ AT WEEK 2
- DUPIXENT 300MG SQ EVERY OTHER WEEK
- IVIG IV
  - GAMMAGARD LIQUID
  - GAMUNEX - C
  - BIVIGAM
  - GAMMAKED 10%
  - HYQVIA
  - FLEBOGAMMA 5%
  - FLEBOGAMMA 10%
  - PRIVIGEN 10%
  - GAMMAGARD S/D
  - GAMMAPLEX 5%

**REFILLS**

1 YEAR

\_\_\_\_\_

OTHER: \_\_\_\_\_

DOSAGE: \_\_\_\_\_ GM/KG DIVIDED OVER \_\_\_\_\_ DAY(S)  
DOSAGE: \_\_\_\_\_ GM DIVIDED OVER \_\_\_\_\_ DAY(S)

FREQUENCY: EVERY \_\_\_\_\_ WEEKS FOR ONE YEAR  
FREQUENCY: EVERY \_\_\_\_\_ WEEKS FOR \_\_\_\_\_

## PRE-MEDICATIONS

\*PLEASE INDICATE PRE-MEDS FOR ALL IVIG MEDICATIONS\*

BENADRYL IV \_\_\_\_\_ MG  
 REGLAN IV \_\_\_\_\_ MG  
 SOLUMEDROL IV \_\_\_\_\_ MG  
 ZOFRAN IV \_\_\_\_\_ MG  
 OTHER IV \_\_\_\_\_ MG

BENADRYL PO \_\_\_\_\_ MG  
 TYLENOL PO \_\_\_\_\_ MG  
 ZYRTEC PO \_\_\_\_\_ MG  
 ZOFRAN PO \_\_\_\_\_ MG  
 ZANTAC PO \_\_\_\_\_ MG  
 OTHER PO \_\_\_\_\_ MG

IF APPLICABLE, DATE OF LAST INFUSION: \_\_\_\_\_

WILL PATIENT BE RE-LOADING?  YES  NO

## MEDICAL INFORMATION

WEIGHT: \_\_\_\_\_ LBS HEIGHT: \_\_\_\_\_ IN  
ALLERGIES: \_\_\_\_\_  N.K.D.A

DATE OF CBC W/ EOS COUNT (CINQAIR, FASENRA, NUCALA): \_\_\_\_\_

DATE OF RAST (XOLAIR): \_\_\_\_\_ IGE SERUM: \_\_\_\_\_ DATE: \_\_\_\_\_

RESULT:  NEGATIVE  POSITIVE

DATE OF IG \_\_\_\_\_ SERUM: \_\_\_\_\_

### PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1 \_\_\_\_\_ DATE RANGE: \_\_\_\_\_  
 #2 \_\_\_\_\_ DATE RANGE: \_\_\_\_\_  
 #3 \_\_\_\_\_ DATE RANGE: \_\_\_\_\_

PATIENT WILL BE DISCONTINUING: \_\_\_\_\_

\*PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES\*

## DIAGNOSIS

- J45.50 SEVERE PERSISTENT ASTHMA, UNCOMPLICATED
- J45.51 SEVERE PERSISTENT ASTHMA WITH (ACUTE) EXACERBATION
- L50.1 CHRONIC IDIOPATHIC URTICARIA
- M30.1 POLYARTERITIS WITH LUNG INVOLVEMENT

OTHER DIAGNOSIS: \_\_\_\_\_  
ICD-10: \_\_\_\_\_

## PHYSICIAN INFORMATION

*By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.*

PHYSICIAN NAME (PRINTED): \_\_\_\_\_ NPI: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

PHYSICIAN NAME (SIGNED): \_\_\_\_\_ DATE: \_\_\_\_\_

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