

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Asthma and Allergy Prescription Form

Patient information

Patient: _____ Female Male DOB: _____ Insurance plan: _____ Plan ID #: _____
 Address: _____ City: _____ State: _____ ZIP code: _____
 Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____
 Other medical conditions: _____ Allergies: No Yes: _____

Clinical information

ICD-10 code: _____ Height: _____ Weight: _____ lb kg Date: _____
 Additional information: Elevated blood eosinophil levels: (mark all that apply)
 ≥ 150 cells/mcL at therapy initiation ≥ 300 cells/mcL in the previous 12 months None listed
 Previous therapies: _____ Present therapies: _____

Prescription information Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Directions	Quantity	Refills
<input type="checkbox"/> Cinqair 100 mg/10 mL vial <input type="checkbox"/> 50 mL sodium chloride for injection	<input type="checkbox"/> Infuse ____ mg (3 mg/kg x ____ kg) IV once every 4 weeks	<input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____	<input type="checkbox"/> 11 <input type="checkbox"/> Other: ____
<input type="checkbox"/> Dupixent <input type="checkbox"/> 200 mg/1.14 mL PFS <input type="checkbox"/> 300 mg/2mL PFS <input type="checkbox"/> 300 mg/2mL PEN	Initial dosing: <input type="checkbox"/> Inject 400 mg SQ initially then 200 mg every other week <input type="checkbox"/> Inject 600 mg SQ initially then 300 mg every other week	<input type="checkbox"/> 14-day supply	0
	Maintenance dosing: <input type="checkbox"/> Inject 200 mg SQ every other week <input type="checkbox"/> Inject 300 mg SQ every other week	<input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____	<input type="checkbox"/> 11 <input type="checkbox"/> Other: ____
<input type="checkbox"/> Fasenra <input type="checkbox"/> 30 mg/mL PFS <input type="checkbox"/> 30 mg/mL auto-injector	Initial dosing: <input type="checkbox"/> Inject 30 mg SQ every 4 weeks for the first 3 doses	<input type="checkbox"/> 84-day supply	0
	Maintenance dosing: <input type="checkbox"/> Inject 30 mg SQ every 8 weeks	<input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____	<input type="checkbox"/> 11 <input type="checkbox"/> Other: ____
<input type="checkbox"/> Nucala <input type="checkbox"/> 100 mg vial <input type="checkbox"/> 100 mg/mL auto-injector <input type="checkbox"/> 100 mg/mL PFS	<input type="checkbox"/> Inject 100 mg under the skin every 4 weeks <input type="checkbox"/> Inject 300 mg under the skin every 4 weeks <input type="checkbox"/> Include sterile water and supplies QS per vial	<input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____	<input type="checkbox"/> 11 <input type="checkbox"/> Other: ____
<input type="checkbox"/> Tezspire <input type="checkbox"/> 210mg/1.91ml PFS	<input type="checkbox"/> Inject 210 mg under the skin every 4 weeks	<input type="checkbox"/> 28-day supply	<input type="checkbox"/> 11 <input type="checkbox"/> Other: ____
<input type="checkbox"/> Xolair <input type="checkbox"/> 150 mg vial <input type="checkbox"/> 75 mg/0.5mL PFS <input type="checkbox"/> 150 mg/mL PFS	<input type="checkbox"/> Inject ____ under the skin every 4 weeks <input type="checkbox"/> Inject ____ under the skin every 2 weeks <input type="checkbox"/> Include sterile water and supplies QS per vial	<input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____	<input type="checkbox"/> 11 <input type="checkbox"/> Other: ____
<input type="checkbox"/> Other: _____	_____ _____ _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____
 Ship to: Patient Office Other: _____
 Office address: _____ City: _____ State: _____ ZIP code: _____
 Office phone number: _____ Office fax number: _____
 Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____
 The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language.
 Noncompliance with state-specific requirements could result in outreach to the prescriber.