ALLERGY IMMUNOLOGY

☐ FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
☐ DALLAS / 3410 Worth St., Ste. 790, Dallas TX 75246

TEL: **817-336-1640** FAX: **817-336-1643**

PATIENT INFORMATION:			**PRESCRIBER INFORMATION:**		
Patient Name:			Prescriber Name:		
Address 1:			DEA:		
Address 2:			NPI:	License:	
City:	State:	Zip:	Address:		
Home Phone:	Alt:		City:	State:	Zip:
DOB: SSN: Gender: ☐ Male ☐ Female			Phone:	Fax:	
Language: ☐ English ☐ Spanish ☐ Other			POC:	Email	

INSURANCE INFORMATION: (Complete entirely or fax front and back of patient's prescription card)

Prescription Card:	Name of Insurer:	ID#	BIN:	PCN:	GROUP:
Primary Insurance:	Subscriber:	ID#	Name of Insurer:	Phone:	
Secondary Insurance:	Subscriber:	ID#	Name of Insurer:	Phone:	

PRIOR AUTHORIZATION: _____

CLINICAL INFORMATION:	**PATIENT HISTORY:**
Diagnosis ☐ J4S.50 Severe persistent asthma, uncomplicated **ICD-10 Code:** ☐ J4S.51 Severe persistent asthma with (acute) exacerbation Eosinophil Count: _____ cells/pt. Date of test: ____/____/_____ ☐ Other: _____ Number of asthma exacerbations (requiring use of systemic corticosteroids and/or hospitalization) in the last 12 months: _____	Weight ☐ kg ☐ lb Height ☐ cm ☐ in ☐ NKDA ☐ Allergies Comorbidities: Concurrent Meds:

PRESCRIPTION INFORMATION: ☐ Ship to Patient ☐ Ship to Physicians office ☐ Injection Training Required? ☐ Yes ☐ No

Medication	Subcutaneous Dose	SIG		Refills
FOR APPROPRIATE PATIENTS WITH: ☐ SEVERE ASTHMA ☐ EOSINOPHILIC GRANULOMATOSIS W/ POLYANGITIS				
☐ Nucala™	☐ 100 mg	☐ 100 mg Every 4 Weeks		
FOR APPROPRIATE PATIENTS WITH: ☐ SEVERE ASTHMA				
☐ Fasenra™	☐ 30 mg	☐ INDUCTION DOSE: 30 mg SUB-Q Every 4 Weeks x First 3 Doses ☐ MAINTENANCE DOSE: 30 mg SUB-Q Every 8 Weeks		

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my 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.

Prescriber Signature: _____ Date: _____