## **BLUEGRASS PHARMACY** | ALLERGIC ASTHMA ENROLLMENT FORM



FAX FORM TO: 1.866.233.8317 | PHONE: 1.855.492.0817 | EMAIL: contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION				2. PRESCRIBER INFORMATION		
Name:				Name:		
Address:				DEA #: NPI #:	State Lic. #:	
City, State, ZIP:				Group or Hospital:		
Primary Phone: DOB: / /				Address:		
Alternate Phone: Gender:				City, State, Zip:		
Email:				Phone: Fax:		
Primary Language:	uage: Last Four of SSN:			Contact Person: Phone:		
3. INSURANCE INFO	ORMATION		Fax copy of <b>presc</b>	<b>ription</b> and <b>insurance cards</b> with this fo	orm, if available (front o	and back
Primary Insurance Company Name:				Secondary Insurance Company Name:		
Primary Cardholder Name:				Secondary Cardholder Name:		
Relationship: Self Spouse/Partner Child/Dependent				Relationship: Self Spouse/Partner Child/Dependen		
Phone: -	- Member II	):	Group #:	Phone: Membe	er ID: Group #:	
4. DIAGNOSIS AND	CLINICAL INFOR	MATION				
Needs by Date: /	/		Ship to: Patient	Office Other:		
Date of Diagnosis:	/ /		Concomitant Therapies:			
O J45	, ,		Short acting beta ago	nist ( ) Inhaled corticosteroid	Oral steroids	
Description: Combination the				y (LAB/ICH) O Long acting beta agonist O Theophylline		
Description.			Leukotriene modifier	○ Immunotherapy	Other:	
			Asthma Severity: O In	ntermittent	Moderate to severe per	sistent
Other: Patient Type:			ew start Continued treatment			
Height (in/cm): Weight (lb/kg): If continuing treatm			If continuing treatment, ha	s asthma control improved with treatment?	○ Yes ○ No	
Medication Allergies: Is patient optimizing			Is patient optimizing use o	f asthma controller or other medication?	○ Yes ○ No	
Concomitant Medications:  Histo			Is patient adherent to asth	ma controller or other medication?	○ Yes ○ No	
			History of positive skin or F	RAST test to a perennial aeroallergen?	○ Yes ○ No	
			Pretreatment serum total I	lgE level (IU/ml test:	Date of Test: /	/
5. PRESCRIPTION II	NFORMATION					
Medication	Dose/Strength Directions				Quantity	Refills
○ Xolair®	150 mg vial kit	Every 4 weeks dosing: Administer 150 mg per dose SQ every 4 weeks.		○ 30-day supply		
		<ul><li>○ Administer 300 mg per dose SQ every 4 weeks.</li><li>○ Administer mg per dose SQ every 4 weeks.</li></ul>			90-day supply     Other:	
		Every 2 weeks dosing: Administer 225 mg per dose SQ every 2 weeks.  Administer 300 mg per dose SQ every 2 weeks.  Administer 375 mg per dose SQ every 2 weeks.				
		Administer 3/3 mg per dose SQ every 2 weeks.  Administer mg per dose SQ every 2 weeks.				
		Please supply one vial of sterile water (10 ml per vial) for every vial of Xolair dispensed and include ancillary supplies (syringe and needle, alcohol swabs).		Ī		
○ EpiPen®		and ir Use as dir		e and needle, alconol swabs).		
○ EpiPen® Jr.	Use as directed.					+
Nucala® (LD)*	(LD)* These are limited	distribution c	drugs that require additional han	dling. Please call (1.855.492.0817) for more infor	mation.	'
○ CINQAIR® (LD)*						
cillary supplies and kits w	vill be provided as nee	eded for admi	nistration.			
6. PRESCRIBER SIG	NATURE					
			/ /	X		/ /
PENSE AS WRITTEN				PRODUCT SUBSTITUTION PERMITTED		, , 

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