BLUEGRASS PHARMACY | ALLERGIC ASTHMA ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the wellpartner Family

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

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ J45. _____
Description:

◯ Other:

Height (in/cm): Weight (lb/kg):

Medication Allergies:

Concomitant Medications:

Concomitant Therapies:

◯ Short acting beta agonist ◯ Inhaled corticosteroid ◯ Oral steroids
◯ Combination therapy (LAB/ICH) ◯ Long acting beta agonist ◯ Theophylline
◯ Leukotriene modifier ◯ Immunotherapy ◯ Other:

Asthma Severity: ◯ Intermittent ◯ Mild persistent ◯ Moderate to severe persistent

Patient Type: ◯ New start ◯ Continued treatment

If continuing treatment, has asthma control improved with treatment? ◯ Yes ◯ No

Is patient optimizing use of asthma controller or other medication? ◯ Yes ◯ No

Is patient adherent to asthma controller or other medication? ◯ Yes ◯ No

History of positive skin or RAST test to a perennial aeroallergen? ◯ Yes ◯ No

Pretreatment serum total IgE level (IU/ml test: Date of Test: / /

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Xolair®	150 mg vial kit	Every 4 weeks dosing: ◯ Administer 150 mg per dose SQ every 4 weeks. ◯ Administer 300 mg per dose SQ every 4 weeks. ◯ Administer _____ mg per dose SQ every 4 weeks. 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 _____ 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).	◯ 30-day supply ◯ 90-day supply ◯ Other:	
◯ EpiPen®		Use as directed.		
◯ EpiPen® Jr.		Use as directed.		
◯ Nucala® (LD)*	(LD)* These are limited distribution drugs that require additional handling. Please call (1.855.492.0817) for more information.			
◯ CINQAIR® (LD)*				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE