IMMUNOLOGY

Garden Grove, CA **toll free** 800.228.3643 **toll free fax** 866.539.1092
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

DATE: _____ NEEDS BY DATE: _____ **SHIP TO:** ❑ OFFICE

PATIENT INFO

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑ J45.40 Moderate Asthma ❑ J45.50 Severe Asthma ❑ L50.1 Chronic Idiopathic Urticaria (CIU)
❑ Other: Dx code_____ Condition _____
Drug Allergies: _____
Concomitant therapies: ❑ Short-acting beta agonist ❑ Long-acting beta agonist ❑ Antihistamines ❑ Decongestants ❑ Immunotherapy
❑ Inhaled corticosteroid ❑ Leukotriene modifiers ❑ Oral steroids ❑ Nasal steroids ❑ Other: _____
Please list therapies: _____
Lab results: ❑ History of positive skin OR RAST test to a perennial aeroallergen
Pretreatment serum IgE level _____ IU per mL Test date _____ Patient weight _____ kg Date weight obtained _____
MD Specialty: ❑ Allergist ❑ Pulmonologist ❑ ENT ❑ Primary care ❑ Pediatrician ❑ Other: _____
Prescription type: ❑ Naïve/new start ❑ Restart ❑ Continuted Therapy Last injection date: _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Xolair® (Patients with Allergic Asthma)	Diluent: 10-mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringes as needed for reconstitution; 25-gauge needles as needed for administration.	SIG ❑ 75mg subcutaneously every 4 weeks SIG ❑ 150mg subcutaneously every 4 weeks SIG ❑ 225mg subcutaneously every 2 weeks SIG ❑ 225mg subcutaneously every 4 weeks SIG ❑ 300mg subcutaneously every 2 weeks SIG ❑ 300mg subcutaneously every 4 weeks SIG ❑ 375mg subcutaneously every 2 weeks	❑ 28 day supply	_____ _____
❑ Xolair® (Patients with CIU)	Diluent: 10-mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringes as needed for reconstitution; 25-gauge needles as needed for administration.	SIG ❑ 150mg subcutaneously every 4 weeks SIG ❑ 300mg subcutaneously every 4 weeks	❑ 28 day supply	_____ _____
❑ EpiPen®	❑ EpiPen®: Injection, 0.3 mg: 0.3 mg/0.3 mL epinephrine, USP, pre-filled auto-injector ❑ EpiPen Jr®: Injection, 0.15 mg: 0.15 mg/0.3 mL epinephrine, USP, pre-filled auto-injector	❑ Inject EpiPen® 0.3 mg intramuscularly or subcutaneously in Patients greater than or equal to 30 kg (66 lbs) ❑ Inject EpiPen Jr® 0.15 mg intramuscularly or subcutaneously in Patients 15 to 30 kg (33 lbs to 66 lbs)	2 2	0 0
❑ Other				

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date

Prescriber's Signature (no stamps) Dispense As Written Date