



SPECIALTY PHARMACY

IMMUNOLOGY

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ☐ OFFICE

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	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 ☐ L20.9 Atopic Dermatitis ☐ 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 ☐ Dermatologist ☐ Other: _____Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continued Therapy Last injection date: _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 300 mg/2 mL PFS w/ shield <input type="checkbox"/> 300 mg/2 mL PFS w/out shield	<input type="checkbox"/> Load: Inject 600 mg (2-300mg injections in different injection sites) on Day 1, then 300 mg on Day 15, then 300 mg every other week. <input type="checkbox"/> Maintenance: Inject 300 mg subcutaneously every other week	4 syringes 2 syringes	none _____
<input type="checkbox"/> 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 <input type="checkbox"/> 75mg subcutaneously every 4 weeks SIG <input type="checkbox"/> 150mg subcutaneously every 4 weeks SIG <input type="checkbox"/> 225mg subcutaneously every 2 weeks SIG <input type="checkbox"/> 225mg subcutaneously every 4 weeks SIG <input type="checkbox"/> 300mg subcutaneously every 2 weeks SIG <input type="checkbox"/> 300mg subcutaneously every 4 weeks SIG <input type="checkbox"/> 375mg subcutaneously every 2 weeks	<input type="checkbox"/> 28 day supply	_____ _____ _____
<input type="checkbox"/> 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 <input type="checkbox"/> 150mg subcutaneously every 4 weeks SIG <input type="checkbox"/> 300mg subcutaneously every 4 weeks	<input type="checkbox"/> 28 day supply	_____ _____
<input type="checkbox"/> EpiPen®	<input type="checkbox"/> EpiPen®: Injection, 0.3 mg: 0.3 mg/0.3 mL epinephrine, USP, pre-filled auto-injector <input type="checkbox"/> EpiPen Jr®: Injection, 0.15 mg: 0.15 mg/0.3 mL epinephrine, USP, pre-filled auto-injector	<input type="checkbox"/> Inject EpiPen® 0.3 mg intramuscularly or subcutaneously in Patients greater than or equal to 30 kg (66 lbs) <input type="checkbox"/> Inject EpiPen Jr® 0.15 mg intramuscularly or subcutaneously in Patients 15 to 30 kg (33 lbs to 66 lbs)	2 2	0 0
<input type="checkbox"/> Other				

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its 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

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