Allergic Asthma Enrollment Form

Express Health Mart Pharmacy
1173 Nostrand ave, Brooklyn, NY 11225
Tel: 347-221-1100 | E-Fax: 347-221-1919
E-mail: ehmpharmacy@gmail.com | www.expresshealthmart.com

6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐Male ☐Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

3 INSURANCE INFORMATION

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

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐Office ☐ Other: _____

Diagnosis:
☐ 493. _____ Asthma
☐ 493. _____ Asthma
Date of Diagnosis: _____

Concomitant Therapies:
☐ Short Acting Beta Agonist ☐ Inhaled Corticosteroid ☐ Oral Steroids
☐ Combination Therapy (LAB/ICH) ☐ Long Acting Beta Agonist ☐ Theophylline
☐ Leukotriene Modifier ☐ Immunotherapy
☐ Other: _____

Patient Evaluation:
Asthma Severity: ☐ intermittent ☐ mild persistent ☐ moderate to severe persistent
Patient type: ☐ New Start ☐ Continued Treatment
If patient is 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
Pretreatment Serum Total IgE Level _____ IU/ml Test Date of Test: _____
History of Positive Skin or RAST Test to a Perennial Aeroallergen ☐ Yes ☐ No
Weight: _____ kg/lbs Allergies: _____
Clinical Impression: _____
Concomitant Medications: _____

5 PRESCRIPTION INFORMATION

MEDICATION		DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Xolair® *(Omalizumab)*	150mg vial kit	*Every 4 weeks dosing:*	☐ Administer 150mg per dose subcutaneously every 4 weeks ☐ Administer 300mg per dose subcutaneously every 4 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 4 weeks ☐ Please supply one vial of sterile water (10ml per vial) for every vial of Xolair® dispensed and include ancillary supplies (syringe and needle, alcohol swabs).	☐ 30-day supply* ☐ 90-day supply* ☐ _____month supply* *Maximum supply subject to health plan benefit limit	☐ 12 months ☐ _____
		Every 2 weeks dosing:	☐ Administer 225mg per dose subcutaneously every 2 weeks ☐ Administer 300mg per dose subcutaneously every 2 weeks ☐ Administer 375mg per dose subcutaneously every 2 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 2 weeks ☐ Please supply one vial of sterile water (10ml per vial) for every vial of Xolair® dispensed and include ancillary supplies (syringe and needle, alcohol swabs).		
☐ EpiPen®		Use as directed.		1	
☐ EpiPen® Jr.		Use as directed.		1	

☐ Patient is interested in patient support programs
Ancillary supplies and kits provided as needed for administration

I certify that the rationale for Xolair® therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.

6 PHYSICIAN SIGNATURE REQUIRED

X _____ X _____
DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

Specialty: ☐ Allergist ☐ Primary Care ☐ ENT ☐ Pulmonologist ☐ Pediatrician ☐ Other: _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Allergic Asthma 031213