Community Memorial Pharmacy
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Allergy/Asthma (E-Z) Ebglyss™, Ilaris®, Nucala®, Rinvoq™, Xolair®

Prescriber Information

Prescriber Name _____ ☐ MD ☐ DO ☐ NP ☐ PA NPI _____

Office Contact _____ Practice Name / Collaborating MD _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name _____ Last 4 Digits of SS# _____ DOB / /

Sex ☐ M ☐ F Weight _____ Height _____ Diabetic? ☐ Y ☐ N

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell _____ HIPAA Contact _____

Emergency # _____

Interpreter Needed? ☐ Y ☐ N | Allergies ☐ Y ☐ N If Yes, list allergies _____

Insurance Information

Primary Insurance _____ Policy ID _____ Group# _____

BIN _____ PCN _____

Policyholder Name _____ Policyholder DOB / /

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

ICD-10/Diagnosis Code ☐ Pulmonary Eosinophilia (J82) ☐ Moderate Persistent Asthma, uncomplicated (J45.40) ☐ Severe Persistent Asthma, uncomplicated (J45.50) ☐ Idiopathic Urticaria (L50.1)
☐ Atopic Dermatitis (L20.9) ☐ Nasal Polyp (J33._____) Eosinophilic esophagitis (K20)
☐ Other _____ FEV1 _____ %

Pre-treatment serum IgE ☐ < 30 IU/mL ☐ ≥30-100 IU/mL ☐ > 100-200 IU/mL ☐ > 200-300 IU/mL
☐ > 300-400 IU/mL ☐ > 400-500 IU/mL ☐ > 500-600 IU/mL ☐ > 600-700 IU/mL
Patient medical history includes ☐ Positive RAST ☐ Positive skin test to perennial aeroallergen
☐ Asthma with eosinophilic phenotype ☐ Other _____
Current maintenance treatment (include dose and frequency) _____
Current exacerbation treatment (include dose and frequency) _____
Patient is a smoker or is exposed to smoke in the home ☐ Y ☐ N
Prior Treatment? ☐ Y ☐ N (Provide Information Below) BSA Affected (%) _____

Affected Areas ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ Other _____

Prior Therapy _____

Reason for Discontinuation of Therapy _____ Approx. Start Date / /
Approx. End Date / /

Comorbidities _____

Concomitant Medications _____

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **EBGLYSS™**	☐ QS for appropriate month of starter dose schedule	Starter Dose ☐ Inject 500 mg (two 250 mg injections) SQ at week 0 and 2, then 250 mg SQ every 2 weeks until 16 or later (when adequate clinical response is achieved)	4 Refills
	☐ 1 carton (1x250 mg/2 ml)	Maintenance Dose ☐ Inject 250 mg SQ every 4 weeks	
☐ **NUCALA®** *Asthma (12 years and older) & CRSwNP (adults) ☐ Pen ☐ PFS	☐ 1 carton (1x100 mg/ml)	☐ Inject 100 mg SQ once every 4 weeks	
☐ **NUCALA®** *HES (patients 12 years and older) and EGPA (adults) ☐ Pen ☐ PFS	☐ 3 cartons (3x100 mg/ml)	☐ Inject 300 mg SQ once every 4 weeks	
☐ **RINVOQ™**	☐ 15 mg tablet (30 day supply) ☐ 30 mg tablet (30 day supply)	☐ Take 1 tablet by mouth daily	
☐ **XOLAIR®** *Pen only for use in ages 12+ ☐ Pen ☐ PFS	☐ Number of 75 mg/0.5 ml pens/syringes _____ ☐ Number of 150 mg/ml pens/syringes _____ ☐ Number of 300 mg/2 ml pens/syringes _____	☐ Inject _____ mg SQ once every _____ weeks	

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____ *Substitution Permitted*
Date _____

Prescriber Signature _____ *Dispense as Written*
Date _____

If brand is required, please write "DAW" in the box to the right. ☐