PALMETTO PHARM
USE AS WRITTEN

Phone: 1-800-275-0139 • Fax: 843-972-9395

Date Shipment Needed:____________ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

PEDIATRIC ASTHMA REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight: ❑lbs. ❑kg.
SSN:	Phone:	Allergies:		
Address:		City:	State:	Zip:
Emergency Contact:	Phone:	❑**Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

❑J82 Pulmonary Eosinophilia ❑J45.40 Moderate Persistent Asthma, uncomplicated ❑J45.50 Severe Persistent Asthma, uncomplicated ❑Other ICD10:____________

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's 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: ❑Yes ❑No

INSURANCE INFORMATION

❑**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑**Please check if enrolling in copay card**	**Copay ID:**

PRESCRIPTION INFORMATION

Medication	QTY	Refills
❑**Dupixent (Dupilumab) 200 mg / 1.14 mL Prefilled Syringe** ❑New start ❑Existing therapy		
❑Starter Dose: Inj. 400 mg (2 syringes) SQ on Day 1, then 200 mg (1 syringe) SQ every other week starting on Day 15	QTY:________	Refills: 0
❑Maintenance Dose: Inj. 200 mg (1 syringe) SQ every 2 weeks	QTY:________	Refills:________
❑**Dupixent (Dupilumab) 300 mg / 2 mL Prefilled Syringe** ❑New start ❑Existing therapy		
❑Starter Dose: Inj. 600 mg (2 syringes) SQ on Day 1, then 300 mg (1 syringe) SQ every 2 weeks starting on Day 15	QTY: 2	Refills: 0
❑Maintenance Dose: Inj. 300 mg (1 syringe) SQ every 2 weeks	QTY: 2	Refills:________
❑**Fasenra® (Benralizumab) 30 mg/mL Prefilled Syringe (OR)** ❑ **Pen** ❑New start ❑Existing therapy		
❑Starter Dose: Administer 30 mg SQ every 4 weeks for 3 doses	QTY: 1 box (1 pen/syringe)	Refills: 2
❑Starter Dose not needed.		
❑Maintenance Dose: Administer 30 mg SQ every 8 weeks	QTY: 1 box (1 pen/syringe)	Refills:________
❑**Xolair® (Omalizumab) 150 mg** ❑**Vial (OR)** ❑**Pre-filled Syringe**		
❑225 mg SQ every 2 weeks	QTY: 1 month	Refills:________
❑300 mg SQ every 2 weeks		
❑375 mg SQ every 2 weeks		
❑75 mg SQ every 4 weeks **(OR)** ❑75 mg Pre-filled Syringe	QTY: 1 month	Refills:________
❑150 mg SQ every 4 weeks		
❑225 mg SQ every 4 weeks		
❑300 mg SQ every 4 weeks		
❑375 mg SQ every 4 weeks		
❑Diluent (sterile water) 10 mL Vial – Use to reconstitute medication	QTY: QS 1 month	Refills:________
❑Syringe 18 g 1 inch (to mix) ❑Needle 25 g (to inj.)	QTY: QS 1 month	Refills:________

I authorize Palmetto Specialty Pharm to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at any time in writing by sending a letter to Palmetto Specialty Pharm 1200 Two Island Ct., Suite B, Unit 100, Mt. Pleasant, SC 29466. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. A copy of this authorization will be utilized with the same effectiveness as the original.

Patient Signature *(required for participation)*____________________ Date ____________

Prescriber's Signature:____________________ ❑ DAW (Dispense as Written) **Date:** ____________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to Palmetto Specialty Pharm or any of its subsidiaries using the contact information provided on this coversheet.

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