HOME PARENTERAL SERVICES

Pulmonology

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Patient Information

Patient name: _____ _____ DOB: _____
Sex: Female Male SSN: _____ _____
Language: _____ Wt: ____ kg lbs Ht: _____ cm in
Address: _ _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ❑ First Fill ❑ Always ❑ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ J45.50 (Severe Persistent Asthma) ❑ L50.1 (Idiopathic Urticaria) ❑ M30.1 (Polyarteritis with lung involvement)

Mutations: _____

Prior Therapy Yes No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____
Concomitant Medications: _____
Allergies: NKDA Other: _____

Prescription		Directions		Refill
❑ **Cinqair**	100 mg/ml vial	Infuse 3 mg/kg IV once every 4 weeks * Patient weight_____kg * Doses will be calculated off of initial weight. Physician will be notified of significant weight change (+/ - 10 %)	28 day supply	_____
❑ **Dupixent**	200mg/1.14ml PFS 2-pack	❑ **Starter Dose**: 400mg (two syringes) subq on Day 1, then 200mg (one syringe) every 2 weeks starting on day 15 and thereafter ❑ **Maintenance Dose**: 200mg subq every 2 weeks	2-200mg/1.14ml PFS	_____
	300mg/2ml PFS 2-pack	❑ **Starter Dose**: 600mg (two syringes) subq on Day 1, then 300mg (one syringe) every 2 weeks starting on day 15 and thereafter ❑ **Maintenance Dose**: 300mg subq every 2 weeks	2-300mg/2ml PFS	_____
❑ **Fasenra**	30 mg/ml PFS	Inject 30 mg subq every 4 weeks for 3 doses, then once every 8 weeks	1-30 mg/ml PFS	_____
❑ **Nucala**	100 mg vial	❑ Inject 100 mg subq every 4 weeks ❑ Inject 300 mg subq every 4 weeks	28 day supply	_____
❑ **Xolair** * Please send script for epi pen with patient to fill at retail pharmacy	❑ Vial ❑ PFS	Every 4 weeks ❑ 150 mg subq every 4 weeks ❑ 300 mg subq every 4 weeks Every 2 weeks ❑ 225 mg subq every 2 weeks ❑ 300 mg subq every 2 weeks ❑ 375 mg subq every 2 weeks	28 day supply	_____

Sterile Water for injection to be dispensed as diluent for Xolair and Nucala vials. Quantity to Dispense: quantity sufficient for 28 day supply Refills:

Injection setting ❑ Physician/ Clinic ❑ HPS ❑ Patient Home

Prescriber's Signature: _____ _____ Date: _____
Substitution Permitted Dispense as Written

I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the prior authorization process.