RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
www.REPharmacy.com

# Eosinophilic Asthma Referral Form

Send your Rx to: (optional)
Select Location

Date Medication Needed: _____ Ship To: (○) Prescriber's Office (○) Pick-Up (store location): _____

## 1) Patient & Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birth Date: _____ Gender: (○) Male (○) Female Height: _____ Weight: _____ (○)lbs. (○)kgs.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Info: _____ Policy Number: _____

## 2) Prescriber Information

Provider Name: _____ Specialty: _____ DEA #: _____ NPI #: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

## 3) Diagnosis/Clinical Information

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

☐ **Patient is 12 years or older** ☐ **Patient is 18 years or older**
☐ Eosinophilic Granulomatosis with polyangiitis (EGPA): _____
☐ Severe Persistent Asthma (uncomplicated) ICD.10-CM J45.50: _____
☐ Severe Persistent Asthma (with acute exacerbation) ICD.10-CM J45.51: _____
☐ Absolute Eosinophil Count: _____ cells/μL: _____ or relative %: _____ ☐ Attach copy of lab results
☐ Pregnancy/Breast Feeding: _____ Other: _____

## 4) Prior Medical History

(Medication and duration of treatment).

**Number of Asthma Exacerbation (that requires systemic steroids in take or hospitalization) in the past 12 months:** _____

**Does patient have (benralizumab), (reslizumab) and/or (mepolizumab) allergy?** (○) Yes (○) No

Reaction Type: _____

☐ Rescue Inhalers more than 2 days/week in the past 3 months:
Drug Name: _____ Dose: _____ Frequency: _____
☐ ICS use in the past 6 months:
Drug Name: _____ Dose: _____ Frequency: _____
☐ Oral Steroids in the past 6 months:
Drug Name: _____ Dose: _____ Frequency: _____

☐ Parasitic Infection (Helminth) ☐ Myalgia
☐ Varicella Zoster Vaccine (Herpes Zoster)
☐ Malignancy (please specify type): _____

**Is patient currently on any other biological drugs?** (○) Yes (○) No

Medications: _____

## 5) Prescription Information

| Medication | Dose/Strength | Sig | Qty | Refills |
|---|---|---|---|---|
| ☐ **Cinqair®** (reslizumab) | ☐ 3mg/kg Comes in 100mg/10ml single use vial | ☐ IV infusion ONLY every 4 weeks over 20-50 min. | | |
| ☐ **Fasenra®** (benralizumab) | ☐ 30mg/ml PFS (First Dose) | ☐ Subcutaneous injection every 4 weeks | 1 | |
| ☐ **Fasenra®** (benralizumab) | ☐ 30mg/ml PFS (Second Dose) | ☐ Subcutaneous injection every 4 weeks | 1 | |
| ☐ **Fasenra®** (benralizumab) | ☐ 30mg/ml PFS (Third Dose) | ☐ Subcutaneous injection every 4 weeks | 1 | |
| ☐ **Fasenra®** (benralizumab) | ☐ 30mg/ml PFS (Maintenance Dose) | ☐ Subcutaneous injection every 8 weeks | 1 | |
| ☐ **Nucala®** (mepolizumab) | ☐ **For EGPA** 300mg (given as 3 separated 100mg injections) | ☐ Subcutaneous injection every 4 weeks | 1 | |
| ☐ **Nucala®** (mepolizumab) | ☐ 100mg | ☐ Subcutaneous injection every 4 weeks | 1 | |

## 6) Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

_____ _____
Patient Signature Date

## 7) Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

_____ _____ _____ _____
Dispense as written Date Substitution Permissable Date



**#of Prescriptions**