VERBAL ORDER FORM
ALLERGY & ASTHMA

PFSP
@pfsprx #pfsprx

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Today's Date _____
Date Needed _____

ACHC ACCREDITED
urac ACCREDITED Specialty Pharmacy Expires 07/01/2023
urac ACCREDITED Rare Disease Pharmacy Center of Excellence Expires 07/01/2023

☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
Ship to: ☐ Physician Office
☐ Nurse / Training
☐ PFSP Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current Medications (if necessary, please fax a complete list)_____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Code
☐ D47.5Hypereosinophilic Syndrome (HES)
☐ J45.5 Severe Persistent Asthma
☐ L20. 9 Atopic dermatitis, unspecified
☐ Other ICD-10 Code:_____
☐ J45.4 Moderate Persistent Asthma
☐ J33.9 & J32.9 Chronic Sinusitis with Nasal Polyposis
☐ M30.1 Eosinophilic Granulomatosis with Plyangiitis (EGPA)

IgE Level:_____ Eosinophil count:_____ Cells/µL Date of test ____/____/_____
Number of exacerbations in the last 12 months:_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

DUPIXENT®
☐ 200mg/1.14ml PFS ☐ 300mg/2mL PFS ☐ 300mg/2mL Pens

ASTHMA, *moderate to severe*:
Initial: ☐ Inject 400mg (two 200mg injections) **OR**
☐ Inject 600mg (two 300mg injections) subcutaneously at day 0
QTY: ☐ 2.28ml or ☐ 4ml Refills: 0
Maintenance: ☐ Inject 200mg **OR** ☐ Inject 300mg subcutaneously once every other week starting on Day 15
QTY: ☐ 2.28ml or ☐ 4ml Refills:____

ASTHMA, *oral corticosteroid dependent or with comorbid moderate to severe atopic dermatitis*:
☐ **Initial:** Inject 600mg (two 300mg injections) subcutaneously at day 0 QTY: 4ml Refills: 0
☐ **Maintenance:** Inject 300mg subcutaneously once every other week starting on day 15 QTY: 4ml Refills:____

☐ RHINOSINUSITIS (CHRONIC) WITH NASAL POLYPOSIS:
SIG: Inject 300mg subcutaneously once every other week
QTY: 4ml Refills:____

ATOPIC DERMATITIS
☐ **Initial:** Inject 600mg (two 300mg injections) subcutaneously at day 0 QTY: 4ml Refills: 0
☐ **Maintenance:** Inject 300mg subcutaneously once every other week starting on day 15 QTY: 4ml Refills:____

☐ Sharps Container ☐ If applicable, enroll patient in MyWay™

OTHER MEDICATION:_____
SIG: _____ QTY:_____ Refills:____

FASENRA® ☐ 30mg/ml Auto-Injector Pen ☐ 30mg/ml PFS
SIG: Inject 30mg subcutaneously once every 4 weeks for the first 3 doses, then once every 8 weeks QTY: 1 Refills:____

NUCALA ☐ 100mg/ml Auto-Injector Pen ☐ 100mg/ml PFS
SIG: Inject 100mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen QTY: 1 Refills:____

RYCLORA™ 2mg/5ml solution
SIG: 2mg by mouth every 4 to 6 hours QTY:_____ Refills:____

RYVENT™ 6mg tablet
SIG: 1 tablet by mouth 3 to 4 times daily QTY:_____ Refills:____

XOLAIR® ☐ 75mg/0.5ml PFS ☐ 150mg/1ml PFS
ASTHMA Pretreatment IgE level:_____units/ml
Patient weight:_____kg
SIG: Inject ____mg subcutaneously ☐ every 4 weeks
OR ☐ every 2 weeks QTY:_____ Refills:____

NASAL POLYPS Pretreatment Serum IgE level:_____units/ml
Patient weight:_____kg
SIG: Inject ____mg subcutaneously ☐ every 4 weeks
OR ☐ every 2 weeks QTY:_____ Refills:____

CHRONIC IDIOPATHIC URTICARIA
SIG: Inject ☐ 150 **OR** ☐ 300mg subcutaneously every 4 weeks
QTY:_____ Refills:____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to **PFSP** at **866-285-7628**
Visit us at **PFSPrx.com** for online fillable forms.
Scan our QR Code to send us feedback about your experience.