CountyMarket Health Mart PHARMACY SPECIALTY CARE

ASTHMA SPECIALTY CARE PROGRAM

Phone: **888-450-4570** • Fax: **855-838-5857**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: ______
Address: ______
City: ______ State: ____ Zip: ______
Phone: ______ Alt. Phone: ______
Email: ______
DOB: ______ Gender: ❍ M ❍ F Caregiver: ______
Height: ______ Weight: ______ Allergies: ______

2 PRESCRIBER INFORMATION:

Name: ______
Address: ______
City: ______ State: ____ Zip: ______
Phone: ______ Fax: ______
NPI: ______ DEA: ______
Tax I.D.: ______
Office Contact: ______ Phone: ______

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3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ______ ICD-10: ______

Other: ______ Date: ______

Assessment: ❑ Moderate ❑ Moderate to Severe ❑ Severe

Number of severe exacerbations in the past 12 months that required systemic corticosteroids, ER visits or hospitalizations: ______

Blood Eosinophil Level: ______ Test Date: ______

IgE Level (if atopic comorbidities) : ______ Test Date: ______

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Biologics	______
❑ ICS	______
❑ ICS + LABA	______
❑ LABA	______
❑ Oral/Injectable Corticosteroids	______
❑ Other Controllers	______

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: ______ Patient's Date of Birth: ______

Medication	Dosage & Strength	Direction	QTY	Refills
❑ DUPIXENT®		**For adults and adolescents 12 years of age and older:**		
	❑ 200mg/1.14ml Prefilled Syringe	❑ **Induction Dose:** Inject 400mg SC on day one	2	0
		❑ **Maintenance:** Inject 200mg SC every other week	2	
	❑ 300mg/2ml Prefilled Syringe	❑ **Induction Dose:** Inject 600mg SC on day one	2	0
		❑ **Maintenance:** Inject 300mg SC every other week	2	
		For patients who require concomitant oral corticosteroids or with comborbid moderate to severe atopic dermatitis for which Dupixent® is indicated, start with an initial dose of 600mg SC followed by 300mg SC given every other week		
❑ ______	______	______		
❑ ______	______	______		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______ Date: ______ Signature: ______ Date: ______

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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