# CoxHealth at Home

# Pulmonology

**PHONE: 1-855-419-4663**
**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 | Qty to Dispense | Refill |
|---|---|---|---|---|
| ❑ **Cinqair** | 100 mg/ml vial | Infuse 3 mg/kg IV once every 4 weeks<br>* Patient weight_____kg<br>* 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**: Inject 400mg SQ on Day 1, followed by maintenance doses | 2 | 0 |
| | | ❑ **Maintenance Dose**: Inject 200mg SQ every 2 weeks | 2 | _____ |
| | ❑ 300mg/2ml PFS 2-pack<br>❑ 300mg/2ml PEN 2-pack | ❑ **Starter Dose**: Inject 600mg SQ on Day 1, followed by maintenance doses | 2 | 0 |
| | | ❑ **Maintenance Dose**: Inject 300mg SQ every 2 weeks | 2 | _____ |
| ❑ **Fasenra** | ❑ 30 mg/ml PFS<br>❑ 30 mg/ml PEN | ❑ **Starter Dose**: Inject 30mg SQ every 4 weeks for 3 doses, followed by maintenance doses | 1 | 2 |
| | | ❑ **Maintenance Dose**: Inject 30mg SQ every 8 weeks | 1 | _____ |
| ❑ **Nucala** | ❑ Vial<br>❑ Autoinjector | ❑ Inject 100 mg SQ every 4 weeks<br>❑ Inject 300 mg SQ every 4 weeks | 28 day supply | _____ |
| ❑ **Xolair**<br>* Please send script for epi pen with patient to fill at retail pharmacy | ❑ Vial<br>❑ PFS | Every 4 weeks: ❑ 150 mg SQ every 4 weeks ❑ 300 mg SQ every 4 weeks<br>Every 2 weeks: ❑ 225 mg SQ every 2 weeks ❑ 300 mg SQ every 2 weeks ❑ 375 mg SQ 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 ❑ CoxHealth at Home Specialty Pharmacy ❑ Patient Home

Prescriber's Signature: _____ Date: _____

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



12-18-2020 Revised Date