benevere PHARMACY

60 Market Center Dr. #103, Collierville, TN 38017
O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560
beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

ASTHMA REFERRAL FORM

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____
DOB _____ SSN _____
Drug Allergies _____ ☐ Male ☐ Female
Patient Weight _____ Height _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____
NPI# _____ Tax ID _____
Practice Name _____
Address _____ Suite _____
City _____ State _____ Zip _____
Office Phone _____ Fax _____
Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____
Policy# _____ Group _____
Insurance Phone _____
Prescription Drug Coverage Company _____
RXGRP# _____ RXBIN# _____

Secondary Insurance (if applicable) _____
Policy# _____ Group _____
Insurance Phone _____
Phone _____
PCN/ID# (if available) _____

CLINICAL INFORMATION

Primary Diagnosis: _____ ICD-10: _____

Current Therapies: ☐ Antihistamines ☐ Beta agonist (circle one): ☐ Long-acting ☐ Short-acting ☐ Corticosteroids (circle one): ☐ Inhaled ☐ Nasal ☐ Oral ☐ Decongestants ☐ Immunotherapy _____ months ☐ Leukotriene modifers ☐ Other: _____

Previous Treatment: ☐ Naive ☐ Restart ☐ Continued therapy; date: _____

Lab results: ☐ History of positive skin OR RAST test to a perennial aeroallergen ☐ Pretreatment serum IgE level_____IU/mL; date_____ ☐ Other _____

PLEASE ATTACH A LIST OF PATIENT'S CURRENT MEDICATIONS.

DRUG NAME	DOSE/FREQUENCY	DIRECTIONS FOR USE	QUANTITY	REFILLS
☐ Dupixent®	☐ 200mg PFS ☐ 300mg PFS	☐ Induction: Inject 2 syringes under the skin on day 1, begin maintenance on day 15. ☐ Maintenance: Inject 1 syringe under the skin every other week.	14-day supply	0
			28-day supply	
☐ Fasenra®	☐ 30mg PFS	☐ Induction: Inject 30mg under the skin every 4 weeks for 3 doses. ☐ Maintenance: Inject 30mg under the skin every 8 weeks	84-day supply	0
			56-day supply	
☐ Xolair® Limited Distribution	☐ 150 mg vial ☐ Xolair Supplies ☐ EpiPen ☐ EpiPen Jr. ☐ No supplies	☐ Inject _____ under the skin every 4 weeks ☐ Inject _____ under the skin every 2 weeks ****Dose based on IgE level and weight. Please provide pertinent laboratory data.*	28-day supply	

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

Statement of Medical Necessity: I certify the prescribed therapy is medically necessary. I will be supervising the patient's treatment accordingly and all information is accurate to the best of my knowledge. I authorize Benevere as my designated agent and on behalf of my patient to (1) provide any information on this form to the insurer of the above name patient and to (2) forward the above prescription by fax or other mode of delivery to the pharmacy chosen by the above named patient.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____