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 ____________________
Insurance Phone ____________________
Secondary Insurance (if applicable) ____________________
Insurance Phone ____________________

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 28-day supply	0
☐ Fasenra®	☐ 30mg PFS ☐ 30mg Pen	☐ Induction: Inject 30mg under the skin every 4 weeks for 3 doses. ☐ Maintenance: Inject 30mg under the skin every 8 weeks	84-day supply 56-day supply	0
☐ Nucala®	☐ 100mg vial	☐ Inject 100mg under the skin every 4 weeks. ☐ Inject 300mg under the skin every 4 weeks.	28-day supply	
☐ Xolair®	☐ 150 mg vial ☐ 150 mg PFS ☐ 75 mg PFS	☐ Inject _______ under the skin every 4 weeks ☐ Inject _______ under the skin every 2 weeks ☐ Xolair Supplies ☐ EpiPen ☐ EpiPen Jr. ☐ No supplies ****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

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.