Phone: (844) 431 – 7277

Fax: (844) 432 - 7277

Asthma

For pharmacy locations, please scan QR code.

Specialty Pharmacy Services Enrollment Form

New York Prescribers, please submit an electronic prescription together with the Enrollment Form

PATIENT INFORMATION

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: M F	Weight:	Height:	Diabetic: Y N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? Y N		

PRESCRIBER INFORMATION

Prescriber Name: MD DO NP PA NPI:	
	Supervising Physician, if applicable:
Address:	City:
State: Zip: Phone:	Fax:

INSURANCE INFORMATION | PLEASE SEND COPY OF INSURANCE CARD

Primary Insurance:	Policy ID:	Group #:
Policyholder Name:	Policyholder DOB:	BIN: PCN:

CLINICAL INFORMATION | PLEASE SEND COPY OF PROGRESS NOTES AND LAB REPORTS SUPPORTING DIAGNOSIS

ICD-10 Diagnosis Code:	Moderate Persistent Asthma, uncomplicated (J45.40)	Severe persistent asthma, uncomplicated (J45.50)	Severe persistent asthma with (acute) exacerbation (J45.51)
Eosinophilic asthma (J82.83)	Eosinophilic granulomatosis with polyangiitis (M30.1)	Hypereosinophilic Syndrome (D72.119)	Nasal polyp (J33)
Idiopathic urticaria (L50.1)	Other: ______		

Concomitant Treatment Yes (List Below) No

Medication	Dose/Strength	Sig	Quantity	Refills

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Sig	Quantity	Refills
Fasenra Pre-Filled Syringe	10 mg/0.5mL 30 mg/mL	Inject 10 mg SQ every 4 weeks for 3 doses, then 10 mg SQ every 8 weeks Inject 30 mg SQ every 4 weeks for 3 doses, then 30 mg SQ every 8 weeks		
Fasenra Autoinjector	30 mg/mL	Inject 30 mg SQ every 4 weeks for 3 doses, then 30 mg SQ every 8 weeks		
Nucala Pre-Filled Syringe	40 mg/0.4mL 100 mg/mL	Inject 40 mg SQ every 4 weeks Inject 100 mg SQ every 4 weeks Inject 300 mg SQ every 4 weeks		
Nucala Autoinjector	100 mg/mL	Inject 100 mg SQ every 4 weeks Inject 300 mg SQ every 4 weeks		
Xolair Pre-Filled Syringe	75 mg/0.5mL 150 mg/mL 300 mg/mL	Inject 75 mg SQ every __ weeks Inject 150 mg SQ every __ weeks Inject 225 mg SQ every __ weeks Inject 300 mg SQ every __ weeks Inject 375 mg SQ every __ weeks		
Xolair Autoinjector	75 mg/0.5mL 150 mg/mL 300 mg/mL	Inject 75 mg SQ every __ weeks Inject 150 mg SQ every __ weeks Inject 225 mg SQ every __ weeks Inject 300 mg SQ every __ weeks Inject 375 mg SQ every __ weeks		

INJECTION TRAINING

Patient received injection training   Prescriber's office to provide injection technique   Price Chopper Specialty to coordinate injection training

By signing this form and utilizing our services, you are authorizing Price Chopper Specialty to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature:	Date:	Prescriber Signature:	Date:
Substitution Permitted:		Issued: Dispense as Written	

Interchange is mandated unless the practitioner indicates 'Dispense as Written' or 'No Substitution' in accordance with the law.

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