

Date: _____ Auth #: _____ Auth Dates: _____ UPMC prior auth form attached

Patient Information

First Name: _____ Last Name: _____ DOB: _____ SSN: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alternate Phone: _____ Caregiver/ Emergency Contact: _____ Phone: _____
 Weight: _____ Allergies: _____ Latex Allergy: Yes No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
 Insured: _____ Insured: _____
 Phone: _____ Phone: _____
 Policy #: _____ Group #: _____ Policy #: _____ Group #: _____

ICD 10

Diagnosis <input type="checkbox"/> J45.____ Asthma	<input type="checkbox"/> L50.1 Idiopathic Urticaria <input type="checkbox"/> M30.1 Polyarteritis with lung involvement <input type="checkbox"/> Other: _____
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Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
<input type="checkbox"/> Cinqair® (reslizumab)	<input type="checkbox"/> 100mg/10ml vial	<input type="checkbox"/> Infuse _____mg every 4 weeks		
<input type="checkbox"/> Dupixent® (dupilumab)	<input type="checkbox"/> 200mg/1.14ml pfs <input type="checkbox"/> 300mg/2ml pfs <input type="checkbox"/> 300mg/2ml pen	<input type="checkbox"/> Administer 300mg under the skin every 2 weeks <input type="checkbox"/> <u>Initial Dose:</u> Administer two (total of 400mg) subcutaneously on day 1 then one (200mg) every 2 weeks starting on day 15 and thereafter <input type="checkbox"/> <u>Initial Dose:</u> Administer two (total of 600mg) subcutaneously on day 1 then one (300mg) every 2 weeks starting on day 15 and thereafter <input type="checkbox"/> <u>Maintenance Dose:</u> Administer 200mg under the skin every 2 weeks <input type="checkbox"/> <u>Maintenance Dose:</u> Administer 300mg under the skin every 2 weeks		
<input type="checkbox"/> Fasentra™ (benralizumab)	<input type="checkbox"/> 30mg/ml pen <input type="checkbox"/> 30mg/ml pfs	<input type="checkbox"/> Administer 30mg by subcutaneous injection every 4 weeks for the first 3 doses <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 30mg once every 8 weeks		
<input type="checkbox"/> Nucala® (mepolizumab)	<input type="checkbox"/> 100mg vials <input type="checkbox"/> 100mg/ml Autoinjector <input type="checkbox"/> 100mg/ml Pen	<input type="checkbox"/> Administer 100mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 300mg subcutaneously every 4 weeks		
<input type="checkbox"/> Xolair® (omalizumab)	<input type="checkbox"/> 150mg vials <input type="checkbox"/> 75mg/0.5ml pfs <input type="checkbox"/> 150mg/ml pfs	<input type="checkbox"/> Administer 150mg per dose subcutaneously <u>every 4 weeks</u> <input type="checkbox"/> Administer 150mg per dose subcutaneously <u>every 2 weeks</u> <input type="checkbox"/> Administer _____ mg per dose subcutaneously every <input type="checkbox"/> 2 weeks <input type="checkbox"/> 4 weeks	4-week supply	

Prescriber Information

Date Shipment Needed: _____ Ship to: Patient Physician/ Clinic Other: _____
 Physician's Name: _____ Office Contact Name: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Physician's Signature: _____ Date: _____