Allergy/Immunology Enrollment Form

Phone: 602-971-6950 / 877-971-3001
Fax: 877-552-5698

VASCO SPECIALTY-INFUSION
An AleraCare Company

Prescriber Information

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:		Practice Name / Supervising MD:	
Address:		City:	
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

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		

Insurance Information

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

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code: ◯ Pulmonary Eosinophilia (J82) ◯ Moderate Persistent Asthma, uncomplicated (J45.40) ◯ Severe Persistent Asthma, uncomplicated (J45.50) ◯ Idiopathic Urticaria (L50.1)

◯ Atopic Dermatitis (L20.9) ◯ Nasal Polyp (J33._____) ◯ Other:

FEV1: % Pre-treatment serum IgE: ◯ < 30 IU/mL ◯ ≥30-100 IU/mL ◯ > 100-200 IU/mL ◯ > 200-300 IU/mL ◯ > 300-400 IU/mL ◯ > 400-500 IU/mL ◯ > 500-600 IU/mL ◯ > 600-700 IU/mL

Patient medical history includes: ◯ Positive RAST ◯ Positive skin test to perennial aeroallergen ◯ Asthma with eosinophilic phenotype ◯ Other:

Current maintenance treatment (include dose and frequency):

Current exacerbation treatment (include dose and frequency): Patient is a smoker or is exposed to smoke in the home: ◯ Y ◯ N

Prior Treatment? ◯ Y ◯ N (Provide Information Below) BSA affected (%): Affected Areas: ◯ Palms ◯ Soles ◯ Head ◯ Neck ◯ Genitalia ◯ Other:

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: Concomitant Medications:

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **DUPIXENT®**	◯ 1 carton (2x200mg/1.14mL) ◯ 1 carton (2x300mg/2ml)	**Starter Dose:** ◯ Inject 400mg SQ at week 0. Begin Maintenance Dose at week 2 ◯ Inject 600mg SQ at week 0. Begin Maintenance Dose at week 2 **Maintenance Dose:** ◯ Inject 200mg every 2 weeks ◯ Inject 300mg every 2 weeks	No Refills
◯ **FASENRA®**	◯ Autoinjector Pen 30mg/ml (for administration by patient) ◯ Prefilled Syringe 30mg/ml (for administration by healthcare provider at Vasco Infusion)	**Starter Dose:** ◯ Inject 30mg SQ every 4 weeks for 3 doses. **Maintenance Dose:** ◯ Inject 30mg SQ every 8 weeks	
◯ **NUCALA®**	◯ Prefilled Autoinjector 100mg/ml (for administration by patient) ◯ Prefilled Syringe 100mg/ml (for administration by patient) ◯ Injector Vial 100mg/ml (for administration by healthcare provider at Vasco Infusion)	◯ Inject _____ SQ once every 4 weeks.	
◯ Other:			

By signing this form and utilizing our services, you are authorizing VascoRx and its employees to serve as your prior authorization agent in dealing with medical and prescription insurance companies and copay assistance foundation.

Prescriber Signature:	Date

Substitution Permitted

Prescriber Signature:	Date

Dispense as Written

If brand is required, please write "DAW" in the box to the right.