Cosentino's SPECIALTY CARE

RESPIRATORY SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: ______
Address: ______
City: ______ State: ____ Zip: ______
Phone: ______ Alt. Phone: ______
Email: ______
DOB: ______ Gender: ❍ M ❍ F Caregiver: ______
Height: ______ Weight: ______ Allergies: ______

2 PRESCRIBER INFORMATION:

Name: ______
Address: ______
City: ______ State: ____ Zip: ______
Phone: ______ Fax: ______
NPI: ______ DEA: ______
Tax I.D.: ______
Office Contact: ______ Phone: ______

v9.3_061621

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ______ ICD-10: ______ Secondary Diagnosis: ______ Date: ______

❑ **Diagnosis of moderate-to-severe asthma in patients ≥12 years old**
❑ **Diagnosis of moderate-to-severe eosinophilic asthma in patients ≥12 years old**

Diagnosed by: ❑ Pulmonary Function Test ❑ Eosinophilic Level
Assessment: ❑ Moderate ❑ Moderate to Severe ❑ Severe

Number of severe exacerbations in the past 12 months that required systemic corticosteroids, ER visits or hospitalizations: ______

Blood Eosinophil Level: ______ Test Date: ______
IgE Level (if atopic comorbidities) : ______ Test Date: ______

Pulmonary Function Test Results:
Pre-bronchodilator FEV1: ______ Test Date: ______
FeNO levels (if applicable): ______ Test Date: ______

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Biologics	______
❑ ICS	______
❑ ICS + LABA	______
❑ LABA	______
❑ Nebulizer	______
❑ Oral Corticosteroids	______
❑ Other	______

❑ **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) in patients ≥18 years old**

Diagnosed by: ❑ Rhinoscopy ❑ Nasal endoscopy ❑ CT Scan
Documentation of Ongoing Symptoms?
❑ Nasal Obstruction or Discharge ❑ Facial Pain or Pressure
❑ Reduction in or Loss of Smell ❑ N/A

Results and date of last CT scan or endoscopy, including polyp location/catheterization, if applicable: ______ Test Date: ______

History of Nasal Surgeries and Procedures? ❑ Yes ❑ No
❑ Endoscopic Polyp Removal (Polypectomy)
❑ Functional Endoscopic Sinus Surgery (FESS)
❑ Other: ______
If no, reason(s) patient may not be a candidate for surgery:
______

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Oral Corticosteroids	______
❑ Intranasal Corticosteroids	______
❑ Medicated or Saline Nasal Rinse	______
❑ Surgery	______
❑ Other	______

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING:
❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:
❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION:
Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: ______ Patient's Date of Birth: ______

Medication	Dosage & Strength	Direction	QTY	Refills
❑ DUPIXENT®	❑ 300mg/2ml Prefilled Syringe ❑ 200mg/1.14ml Prefilled Pen ❑ 200mg/1.14ml Prefilled Syringe ❑ 300mg/2ml Prefilled Pen (only for 12 years and older)	**For adults and adolescents 12 years of age and older:**		
		❑ **Induction Dose:** Inject 400mg SC on day one	2	0
		❑ **Maintenance:** Inject 200mg SC every other week	2	
		❑ **Induction Dose:** Inject 600mg SC on day one	2	0
		❑ **Maintenance:** Inject 300mg SC every other week	2	
		For adults with chronic rhinosinusitis with nasal polyposis: ❑ Inject 300mg SC every other week	2	
❑ ______	______	______		

For patients who require concomitant oral corticosteroids or with comborbid moderate to severe atopic dermatitis for which Dupixent® is indicated, start with an initial dose of 600mg SC followed by 300mg SC given every other week

PRESCRIBER SIGNATURE:
I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______ Date: ______
Substitution Permitted

Signature: ______ Date: ______
Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.

© 2020 KloudScript, Inc. - All rights reserved.