MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

ALLERGY AND ASTHMA

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ ASMANEX	☐ 50MCG ☐ 100MCG ☐ 110MCG ☐ 200MCG ☐ 220MCG	☐ INHALE____MCG ONCE DAILY IN THE EVENING ☐ INHALE____MCG TWICE DAILY	1 DEVICE	
☐ AUVI-Q	☐ .15MG/.15ML ☐ 0.1MG/0.1ML ☐ .3MG/.3ML	☐ USE AS DIRECTED BY PRESCRIBER	1 BOX (2 PENS)	
☐ BREYNA	☐ 80MCG/4.5MCG ☐ 160MCG/4.5MCG	☐ INHALE 2 PUFFS TWICE DAILY	1 DEVICE	
☐ DULERA	☐ 50MCG/5MCG ☐ 100MCG/5MCG ☐ 200MCG/5MCG	☐ INHALE 2 PUFFS TWICE DAILY	1 DEVICE	

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

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PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ DUPIXENT	☐ 200MG/1.4ML PFS ☐ 200MG/1.4ML AUTOINJECTOR ☐ 300MG/1.4ML PFS ☐ 300MG/1.4ML AUTOINJECTOR	☐ INITIAL DOSE: INJECT ____MG SQ ON DAY 1 AND ____MG SQ ON DAY 15 ☐ MAINTENANCE DOSE: INJECT ____MG SQ EVERY ____WEEKS		
☐ ELLIPTA (arnuity)	☐ 50MCG ☐ 100MCG ☐ 200MCG	☐ INHALE 1 PUFF ONCE DAILY	1 DEVICE	
☐ ELLIPTA (breo)	☐ 50MCG/25MCG ☐ 100MCG/25MCG ☐ 200MCG/25MCG	☐ INHALE 1 PUFF ONCE DAILY	1 DEVICE	
☐ ELIPTA (trelegy)	☐ 100MCG/62.5MCG ☐ 200MCG/62.5MCG	☐ INHALE 1 PUFF ONCE DAILY	1 DEVICE	

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Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ FASENRA	☐ 30MG/ML AUTOINJECTOR ☐ 30MG/ML PFS	☐ INJECT_____MG SQ EVERY_____DAYS		
☐ GRASTEK	☐ 2800U TAB	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ KARBINAL ER	☐ 4MG/5ML ORAL SOLUTION	☐ TAKE_____ML BY MOUTH EVERY_____HOURS		
☐ NEFFY	☐ 1MG NASAL SPRAY ☐ 2MG NASAL SPRAY	☐ USE AS DIRECTED BY PRESCRIBER	1 DEVICE	
☐ NUCALA	☐ 100MG/ML PFS ☐ 100MG/ML AUTOINJECTOR	☐ INJECT_____MG SQ EVERY_____DAYS		
☐ ODACTRA	☐ 12SQ-HDM TABLET	☐ PLACE 1 TABLET UNDER THE TONGUE TO DISSOLVE. DO NOT SWALLOW FOR AT LEAST 1 MINUTE. ADMINISTER THE FIRST DOSE UNDER THE SUPERVISION OF PRESCRIBER.	[30]	
☐ OMNARIS	☐ 50MCG NASAL SPRAY	☐ ADMINISTER 2 SPRAYS IN EACH NOSTRIL ONCE DAILY	1 DEVICE	
☐ RAGWITEK	☐ 12U TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	

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Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ RHAPSIDO	☐ 25MG TABLET	☐ TAKE 1 TABLET BY MOUTH TWICE DAILY	[60]	
☐ RYALTRIS	☐ 665MCG/25MCG NASAL SPRAY	☐ ADMINISTER 2 SPRAYS IN EACH NOSTRIL TWICE DAILY	1 DEVICE	
☐ TEZSPIRE	☐ 210MG AUTOINJECTOR ☐ 210MG PFS	☐ INJECT 200MG SQ EVERY 4 WEEKS		
☐ XOLAIR	☐ 75MG AUTOINJECTOR ☐ 75MG PFS ☐ 150MG AUTOINJECTOR ☐ 150MG PFS ☐ 300MG AUTOINJECTOR ☐ 300MG PFS	☐ INJECT_____MG SQ EVERY_____DAYS		
☐ WIXELA	☐ 100MCG/50MCG ☐ 250MCG/50MCG ☐ 500MCG/50MCG	☐ INHALE 1 PUFF TWICE DAILY	1 DEVICE	

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