LINDEN
RETAIL SPECIALTY PHARMACY

ASTHMA ENROLLMENT FORM
MEDICATIONS A-E

Phone: 908-583-6665 | Fax: 888-474-0976
Email: lindensprx@gmail.com

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name _____ Address _____ City, State, ZIP _____

Preferred Contact Methods ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone _____ Alternate Phone _____ Date of Birth _____ Gender ◯ Male ◯ Female

Email _____ Last Four of SSN _____ Primary Language _____

2 PRESCRIBER INFORMATION

Prescriber's Name _____ State License Number _____

NPI Number _____ DEA Number _____ Group or Hospital _____

Address _____ City, State, ZIP _____

Phone _____ Fax _____ Contact Person _____ Contact's Phone _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date _____ Ship to ☐ Patient ☐ Office ☐ Other _____

Diagnosis (ICD-10):

☐ E22.0 acromegaly and pituitary giantism ☐ Other Code _____ Description _____

Patient Clinical Information

Allergies _____ Height _____ in/cm Weight _____ lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cinqair (reslizumab)	100 mg / 10 mL vial	Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes Include sodium chloride and supplies sufficient for medication days supply • IV administration/infusion set (0.2micron filter) • IV Cath Insyte autoguard or PIV insertion kit • Ultrasyte needle-free connector (one per vial shipped) • 30mL syringe (one per vial shipped) • 50mL 0.9% NaCl • 2 – 10mL 0.9% NaCl flush • Alcohol swabs	Quantity: _____ vials ☐ 30-day supply ☐ 90-day supply ☐ ____-day supply Refills: ☐ 1 year ☐ Other: _____
☐ Dupixent (dupilumab) ☐ 200 mg/1.14ml PFS ☐ 300 mg/2mL PFS		**Initial Dose:** ☐ Inject 400mg SC (2-200mg injections in different injection sites) initially then 200mg SC every other week ☐ Inject 600mg SC (2-300mg injections in different injection sites) initially then 200mg SC every other week **Maintenance Dose:** ☐ Inject 200mg (one injection) SC every other week ☐ Inject 300mg (one injection) SC every other week	Quantity: _____ Refills: _____

5 PHYSICIAN SIGNATURE REQUIRED

Product Substitution Permitted _____ (Date) _____ Dispense as Written _____ (Date) _____

LINDEN
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ASTHMA ENROLLMENT FORM
Medications F-Z

Phone: 908-583-6665 | Fax: 888-474-0976
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Please complete Patient and Prescriber information

Patient Name: _____ Patient Date Of Birth: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Fasenra (benralizumab)	30 mg/mL pre-filled syringe	☐ Administer 30mg/mL by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter ☐ Other: Administer _____	Quantity: ☐ 1 pre-filled syringe ☐ 3 pre-filled syringes Refills: ☐ 1 year ☐ Other: _____
☐ Nucala (mepolizumab)	100 mg vial	**SEVERE ASTHMA** ☐ Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen **EOSINOPHILIC GRANULOMATOSIS WITH POLYAGNIITIS (EGPA)** ☐ Inject 300 mg as 3 separate 100mg subcutaneous injections once every 4 weeks into the upper arm, thigh or abdomen ☐ Include sterile water and supplies sufficient for medication days supply ☐ No supplies requested (supplies will be sent with shipment unless indicated) • One 10 mL vial sterile water for injection for every vial of Nucala® dispensed • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution • 1 mL polypropylene syringe with 21G to 27G x ½" needle for subcutaneous injection	Quantity: ☐ 30-day supply ☐ 90-day supply ☐ ____-day supply Refills: ☐ 1 year ☐ Other: _____
☐ Xolair (omalizumab)	**Vial** ☐ 150 mg vial kit **PFS** ☐ 75mg/0.5ml pre-filled syringe ☐ 150mg/1ml pre-filled syringe	**Every 4 weeks dosing:** ☐ Administer 75 mg per dose subcutaneously every 4 weeks ☐ Administer 150 mg per dose subcutaneously every 4 weeks ☐ Administer 225 mg per dose subcutaneously every 4 weeks ☐ Administer 300 mg per dose subcutaneously every 4 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 4 weeks **Every 2 weeks dosing:** ☐ Administer 225 mg per dose subcutaneously every 2 weeks ☐ Administer 300 mg per dose subcutaneously every 2 weeks ☐ Administer 375 mg per dose subcutaneously every 2 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 2 weeks **For Xolair Vials only:** ☐ Include sterile water and supplies sufficient for medication days supply ☐ No supplies requested (supplies will be sent with shipment unless indicated) • One 10 mL vial sterile water for injection for every vial of Xolair® dispensed • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL Luer Lock injection syringe • NDL 18G x 1½" Safety Glide needle for reconstitution • NDL 25G x ⅝" Safety Glide needle for subcutaneous injection	Quantity: ☐ 30-day supply ☐ 90-day supply ☐ ____-day supply Refills: ☐ 1 year ☐ Other: _____

5 PHYSICIAN SIGNATURE REQUIRED

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Nursing Medications

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Please complete Patient and Prescriber information

Patient Name: _____ Patient Date Of Birth: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____
☐ Epipen	☐ Other: _____	Use as directed.	Quantity: 1 Refills: _____
☐ Epipen Jr.	☐ Other: _____	Use as directed.	Quantity: 1 Refills: _____

5 PHYSICIAN SIGNATURE REQUIRED

Product Substitution Permitted _____ (Date) _____ Dispense as Written _____ (Date) _____