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www.rxuniversal.com

Allergy / Asthma Referral Form

Urgent/Stat **Standard**

Prescriber

Prescriber Information

Prescriber Name:			MD PA NP	
NPI:		DEA:	Office Contact:	
Address:				
City:	State:	Zip:	Phone #:	Fax #:

Patient

Patient Information - Fax A Copy Of The Front And Back Of All Insurance Cards

First Name:		MI:	Last Name:	
DOB:	Sex: M F	Last 4 Digits SSN :	Interpreter: Y N Specify:	
Address:				
City:	State:	Zip:	Primary #:	Alternate #:
Emergency Contact:	Phone #:		Contact Preference: AM Noon PM	

Clinical

Clinical Information - Please Send Progress Notes, Lab Reports And Any Other Supporting Documents

ICD10/ Diagnosis Code: Pulmonary Eosinophilia(J82) Moderate Persistent Asthma, uncomplicated(J45.40) Idiopathic Urticaria(L50.1) Atopic Dermatitis(L20.9)

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):

Is the patient a smoker or 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:

Previous Therapies: Continuity of care: / /

Comorbidities: Allergies: NKDA Other

Prescription

Prescription Information

New Prescription Refill Prescription Deliver to: Patient's Home Prescriber's Office Other Start Date: / /

Drug		Directions & Quantity	Refills
Dupixent®	ACT Pen	Initial: Inject 400 mg SQ (two 200 mg injections) SQ on day 1(Quantity: 2) Maintenance: Inject 200 mg SQ every other week starting at day 15 (Quantity: 2)	
	Pre-filled Syringe	Initial: Inject 600 mg SQ (two 300 mg injections) SQ on day 1(Quantity: 2) Maintenance: Inject 300 mg SQ every other week starting at day 15 (Quantity: 2)	
Nucala®	100 mg Vial	Inject 100 mg SQ once every 4 weeks (Quantity:1)	
Xolair®	150 mg/ 3mL vials	Inject _____mg SQ once every _____ weeks	
Sterile Water for Injection	Number of vials	Use with Xolair® as directed	
Other			

Dispense ancillary supplies, syringes and medical equipment necessary to administer medication.

Injection Training

Patient received injection training Prescriber's office to provide injection training Universal to coordinate injection training

By signing this form and utilizing our services, you are authorizing Universal Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Sign

Prescriber Signature and Date (Required to validate prescription)

Physician Signature: Date: / /

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