POLARIS SPECIALTY RX

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Polaris Specialty Pharmacy
410 Cloverleaf Drive
Baldwin Park, CA 91706
NPI: 1053486795

ASTHMA-ALLERGY ORDER FORM

Ship to: ☐ Patient ☐ Physician ☐ Other **Need:** ☐ Nurse ☐ Training
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Patient Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____

Email: _____

Parent or Guardian Contact Info: _____

Allergies: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information

Diagnosis: Date of Diagnosis: _____

☐ J45 Asthma
☐ K20.0 Eosinophilic Esophagitis
☐ L50.8 Chronic Spontaneous Urticaria
☐ J33 Chronic Rhinosinusitis with Nasal Polyps
☐ D72.11 Hypereosinophilic Syndrome
☐ M30.1 Eosinophilic granulomatosis with Polyangiitis
☐ Other: _____

Weight: _____ ☐ kg ☐ lbs Serum IgE Level: _____IU/mL

Tried and Failed History:

Medication: _____ Duration: _____

Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side Effects ☐ Other: _____

Prescription Information

Medication	Strength	Directions	Quantity	Refills
☐ Cinqair	☐ 100mg/10ml Vial	☐ 3mg/kg IV every 4 weeks infused over 20-50 minutes	_____	_____
☐ Dupixent	☐ 200mg/1.14mL Prefilled Syringe ☐ 200mg/1.14mL Prefilled Pen ☐ 300mg/2mL Prefilled Syringe ☐ 300mg/2mL Prefilled Pen	**For Asthma:** ☐ **Initial Dose:** 400mg subcutaneously on day 1 ☐ **Maintenance:** 200mg subcutaneously every 2 weeks starting on day 15 ☐ **Initial Dose:** 600mg subcutaneously on day 1 ☐ **Maintenance:** 300mg subcutaneously every 2 weeks starting on day 15	2 2 2 2	None _____ None _____
☐ Dupixent	☐ 300mg/2mL Prefilled Syringe ☐ 300mg/2mL Prefilled Pen	**For Eosinophilic Esophagitis:** ☐ 300mg subcutaneously every week **For Chronic Rhinosinusitis with Nasal Polyps:** ☐ 300mg subcutaneously every 2 weeks	4 2	_____ _____
☐ Fasenra	☐ 30mg/mL Prefilled Syringe ☐ 30mg/mL Prefilled Pen	**For Asthma:** ☐ **Initial Dose:** 30mg subcutaneously every 4 weeks for 3 doses ☐ **Maintenance:** 30mg subcutaneously every 8 weeks	1 1	2 _____

Referral form continued on next page

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Prescription Information

Medication	Strength	Directions	Quantity	Refills
☐ Nucala	☐ 100mg Vial Powder for Resconstitution ☐ 100mg/ml Vial	**For Asthma or Chronic Rhinosinusitis with Nasal Polyps:** ☐ 100mg subcutaneously every 4 weeks **For Eosinophilic granulomatosis with Polyangiitis or Hypereosinophilic Syndrome** ☐ 300mg subcutaneously every 4 weeks	1 3	_____ _____
☐ Xolair	☐ 75mg/0.5mL Prefilled Syringe ☐ 150mg/mL Prefilled Syringe ☐ 150mg Vial	**For Asthma** ☐ _____mg (150mg to 375mg) subcutaneously every _____ weeks **For Chronic Spontaneous Urticaria** ☐ _____mg (150mg to 300mg) subcutaneously every 4 weeks **For Nasal Polyps** ☐ _____mg (75mg to 600mg) subcutaneously every _____ weeks	_____ _____ _____	_____ _____ _____
☐ Other medication and strength: _____		Directions: _____	_____	_____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____ E-Mail: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

I authorize Polaris Specialty Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ ☐ **Dispense as written (DAW) Date:** _____/_____/_____

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