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

PULMONOLOGY 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: _____

Alternate Contact Info: _____

Gender: ☐ Male ☐ Female Allergies: _____

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

Clinical Information

Diagnosis: Date of Diagnosis: _____
☐ J82 Pulmonary Eosinophilia
☐ J45.40 Moderate Persistent Asthma, uncomplicated
☐ J45.50 Severe Persistent Asthma, uncomplicated
☐ Other Diagnosis: ICD-10 Code

Description: _____

FEV1 _____%

Pre-treatment IgE: ☐ <30IU/ml ☐ ≥30-100IU/ml
☐ >100-200IU/ml ☐ >200-300IU/ml
☐ >300-400IU/ml ☐ >400-500IU/ml
☐ >500-600IU/ml ☐ >600-700IU/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): _____

Prior Therapy: _____ Approx Start Date: _____

Reason for Discontinue Therapy: _____ Approx Stop Date: _____

Comorbidities: _____

Concomitant Medications: _____

Prescription Information

Medication	Strength	Directions	Quantity	Refills
☐ Dupixent	☐ 300mg/2ml PF Syringe ☐ 300mg/2ml PF Pen ☐ 200mg/1.14ml PF Syringe ☐ 200mg/1.14ml PF Pen	**For Adult and Pediatric Patients 12 years and older with Asthma** **Initial Dosing:** ☐ Inject 400mg (two 200mg injections) SQ at week 0 ☐ Inject 600mg (two 300mg injections) SQ at week 0 **Subsequent Dosing:** ☐ Inject 200mg SQ every 2 weeks starting at week 2 ☐ Inject 300mg SQ every 2 weeks starting at week 2	 2 2 2 2	 None None _____ _____
		For Patients with Oral Corticosteroid-Dependent Asthma or Adults with Co-Morbid Chronic Rhinosinusitis with Nasal Polyposis **Initial Dosing:** ☐ Inject 600mg (two 300mg injections) SQ at week 0 **Subsequent Dosing:** ☐ Inject 300mg SQ every 2 weeks starting at week 2	 2 2	 None _____

Referral form continued on the next page

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☐ Fasenra	☐ 30mg/mL PF Syringe ☐ 30mg/mL PF Pen	**For Asthma:** ☐ **Initial Dose:** 30mg subcutaneously every 4 weeks for 3 doses ☐ **Maintenance:** 30mg subcutaneously every 8 weeks	1 1	2 _____
☐ Nucala	☐ 100mg/ml PF Autoinjector ☐ 100mg/ml PF Glass Syringe ☐ 40mg/0.4ml PF Glass Syringe	**For Adult and Adolescent Patients 12 years and older** ☐ Inject 100mg SQ every 4 weeks into the upper arm, thigh, or abdomen	1	_____
		For Pediatric Patients Aged 6 to 11 years ☐ Inject 40mg SQ every 4 weeks into the upper arm, thigh, or abdomen	1	_____
☐ Xolair	☐ 75mg/0.5mL PF Syringe ☐ 150mg/mL PF Syringe ☐ 150mg Vial	**For Asthma** ☐ _____mg (150mg to 375mg) subcutaneously every _____weeks	_____	_____
☐ Other: _____			_____	_____

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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