

**PATIENT INFORMATION** – please attach a copy of the patient’s insurance card

Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City   State   Zip Code:			
Primary Phone:		Secondary Phone:		Language:	
Allergies (Required):		<input type="checkbox"/> NKDA		Height:	Weight:
SSN:					
Therapy Shipping Options: <input type="checkbox"/> Patient’s Home <input type="checkbox"/> Prescriber’s Office <input type="checkbox"/> Alternative Address:					

**PRESCRIBER INFORMATION**

Practice Name:		Office Contact:			
Prescriber:		NPI:		DEA:	
Practice Address:		City   State   Zip Code::			
Office Phone:		Office Fax:			

**CLINICAL INFORMATION** – please fax all pertinent clinical and lab information

ICD – 10 / Diagnosis:		Office Contact:			
Prescriber:		NPI:		DEA:	
Practice Address:		City   State   Zip Code::			
Office Phone:		Office Fax:			

**PRESCRIPTION INFORMATION**

Medication	Form	Directions	Quantity	Refills
<input type="checkbox"/> Epipen®	Pen	Use as directed	1 Box	
<input type="checkbox"/> Epipen® Jr.	Pen	Use as directed	1 Box	
<input type="checkbox"/> Fasentra® (benralizumab)	<input type="checkbox"/> PFS	<input type="checkbox"/> Inject 30 mg subcutaneously every 4 weeks for first 3 dose Injection	[ ] 30 mg / mL	
	<input type="checkbox"/> PFS	<input type="checkbox"/> 30 mg subcutaneously every 8 weeks for maintenance dose	[ ] 30 mg / mL	
<input type="checkbox"/> Nucala® (mepolizumab)	<input type="checkbox"/> Vials	<input type="checkbox"/> Inject 100 mg subcutaneously every 4 weeks	[ ] 100 mg / mL	
	<input type="checkbox"/> Vials	<input type="checkbox"/> Inject 300 mg ( 3 vials) subcutaneously every 4 weeks	[ ] 100 mg / mL	
<input type="checkbox"/> Dupixent® (dupilumab)	<input type="checkbox"/> PFS	<input type="checkbox"/> Inject 600 mg subcutaneously week 1, then inject 300 mg every other week	[ ] 300 mg / 2 mL	
	<input type="checkbox"/> PFS	<input type="checkbox"/> Inject 600 mg subcutaneously week 1, then inject 300 mg every other week	[ ] 200 mg / 1.14 mL	

**PRESCRIBER SIGNATURE AND DATE**– please sign and date below)

Dispense as Written \_\_\_\_\_ Date \_\_\_\_\_ Substitution Permissible \_\_\_\_\_ Date \_\_\_\_\_

Check here to authorize MedBox and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber’s behalf, “I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge.

Important Notice: This form and its contents may contain private and confidential information that is intended for the individual or entity to which it is addressed. This transmission may contain information that is exempt from disclosure under laws including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Unless explicitly stated, you are strictly prohibited from disseminating, copying or distributing any material contained within. Violators will be prosecuted to the fullest extent of the law. If you received this communication in error, please notify us immediately and destroy this form and its contents.