MedBox

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ALLERGY AND ASTHMA TREATMENT ENROLLMENT FORM

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

Name:		Date of Birth:		☐ Male ☐ Female
Address:		City | State | Zip Code:		
Primary Phone:	Secondary Phone:		Language:	
Allergies (Required): ☐ NKDA		Height:	Weight:	SSN:

Therapy Shipping Options: ☐ Patient's Home ☐ Prescriber's Office ☐ 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
☐ Epipen®	Pen	Use as directed	1 Box	
☐ Epipen® Jr.	Pen	Use as directed	1 Box	
☐ Fasenra® (benralizumab)	☐ PFS	☐ Inject 30 mg subcutaneously every 4 weeks for first 3 dose Injection	[ ] 30 mg / mL	
	☐ PFS	☐ 30 mg subcutaneously every 8 weeks for maintenance dose	[ ] 30 mg / mL	
☐ Nucala® (mepolizumab)	☐ Vials	☐ Inject 100 mg subcutaneously every 4 weeks	[ ] 100 mg / mL	
	☐ Vials	☐ Inject 300 mg (3 vials) subcutaneously every 4 weeks	[ ] 100 mg / mL	
☐ Dupixent® (dupilumab)	☐ PFS	☐ Inject 600 mg subcutaneously week 1, then inject 300 mg every other week	[ ] 300 mg / 2 mL	
	☐ PFS	☐ 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.