RX BIOTECH SPECIALTY PHARMACY
an aureus company

P: 800.657.2212 • F: 888.601.0049
www.RxBiotech.com

Allergy/Immunology

Physician Information

Send updates to: ◯ Fax: ______ ◯ Email: ______ ◯ Text: ______

Prescriber Name:	◯ MD ◯ DO ◯ NP ◯ PA	NPI:
Office Contact:	Practice Name / Supervising MD:	
Address:	City:	
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code: ◯ Pulmonary Eosinophilia (J82) ◯ Moderate Persistent Asthma, uncomplicated (J45.40) ◯ Severe Persistent Asthma, uncomplicated (J45.50)

◯ Idiopathic Urticaria (L50.1) ◯ 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 does and frequency):

Current exacerbation treatment (include does and frequency): | Patient is a smoker or is exposed to smoke in the home: ◯ Y ◯ N

Prescription Information | THESE MEDICATIONS WILL BE SHIPPED DIRECTLY TO THE PROVIDER'S OFFICES

Medication	Dose/Strength	Sig	Quantity	Refills
◯ XOLAIR®	◯ 150mg/5ml vial(s) (Qs for dose)	◯ Inject ______ mg Sub-Q every ______ weeks	28 Day Supply	
◯ Other:				

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

Physician Signature: Date	Physician Signature: Date
Substitution Permitted	Dispense as Written