IMMUNOLOGY **ENROLLMENT FORM**

GREENHILL PLUS+
Specialty Pharmacy Solution
Connection • Care • Community

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Patient Name _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ SSN _____ Gender ○ M ○ F
Weight _____ kg/lbs Height _____ cm/in
Language Preference: ○ English ○ Spanish ○ Other _____
Caregiver Name _____ Relation _____
Local Pharmacy _____ Phone _____
Insurance Plan _____ Plan ID _____
Please fax a copy of front and back of the insurance card(s)

Prescriber Information & Shipping Information

Prescriber's Name _____
NPI _____ DEA _____
License # _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Contact _____
Phone _____ Alternate Phone _____
Fax _____
Email _____
If shipping to prescriber ○ First Fill ○ Always ○ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis ○J45.40 Moderate Asthma ○J45.50 Severe Asthma ○L20.9 Atopic Dermatitis ○L50.1 Chronic Idiopathic Urticaria (CIU) ○Other Dx code_____ Condition_____

Drug Allergies _____

Concomitant therapies ○Short-acting beta agonist ○Long-acting beta agonist ○Antihistamines ○Decongestants ○Immunotherapy ○Inhaled corticosteroid ○Leukotriene modifiers ○Oral steroids ○Nasal steroids ○Other_____
Please list therapies_____

Lab results ○History of positive skin OR RAST test to a perennial aeroallergen
Pretreatment serum IgE level_____IU per mL Test date_____ Patient weight_____kg Date weight obtained_____

MD Specialty ○ Allergist ○Pulmonologist ○ENT ○Primary care ○Pediatrician ○Dermatologist ○Other_____

Prescription type ○ Naïve/new start ○Restart ○ Continuted Therapy Last injection date_____

Prescription Information

Drugs	Dosage/Strength	Directions	Quantity	Refills
○**Dupixent®**	○ 300 mg/2ml PFS w/ shield ○ 300 mg/2ml PFS w/out shield	○Load: Inject 600 mg (2-300mg injections in different injection sites) on Day 1, then 300 mg on Day 15, then 300 mg every other week. ○Maintenance: Inject 300 mg subcutaneously every other week	4 syringes 2 syringes	None _____
○ **Xolair®** (Patients with allergic asthma)	Diluent: 10ml Vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringes as needed for reconstitution; 25-gauge needles as needed for administration.	SIG ○ 75mg subcutaneously every 4 weeks SIG ○ 150mg subcutaneously every 4 weeks SIG ○ 225mg subcutaneously every 2 weeks SIG ○ 225mg subcutaneously every 4 weeks SIG ○ 300mg subcutaneously every 2 weeks SIG ○ 300mg subcutaneously every 4 weeks SIG ○ 375mg subcutaneously every 2 weeks	○ 28 day supply	_____ _____ _____ _____ _____ _____ _____
○ **Xolair®** (Patients with CIU)	Diluent: 10ml Vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringes as needed for reconstitution; 25-gauge needles as needed for administration.	SIG ○ 150mg subcutaneously every 4 weeks SIG ○ 300mg subcutaneously every 4 weeks	○ 28 day supply	_____ _____
○**EpiPen®**	○EpiPen®: Injection, 0.3 mg: 0.3 mg/0.3 mL epinephrine, USP, prefilled auto-injector	○Inject EpiPen® 0.3 mg intramuscularly or subcutaneously in Patients greater than or equal to 30 kg (66 lbs)	2	0
	○EpiPen Jr®: Injection, 0.15 mg: 0.15 mg/0.3 mL epinephrine, USP, prefilled auto-injector	○Inject EpiPen Jr® 0.15 mg intramuscularly or subcutaneously in Patients 15 to 30 kg (33 lbs to 66 lbs)	2	0
○ **Other**	_____	_____	_____	_____

Injection Training Provided by: ○Physician's Office ○Pharmacy ○Other: _____
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Ship to: ○ ***Patient*** ○ ***Office*** ○ ***Other*** _____ ***Date*** _____ ***Needs by Date*** _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: _____ _____ ***Date:*** _____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician / Supervising Physician Signature: _____