Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice.

Sage Specialty Pharmacy Asthma and Allergy Referral Form

WWW.SAGE-SPECIALTYPHARMACY.COM

Patient Information: Please provide a copy of the patient's insurance card or information				
Patient Name:	DOB:	Gender:	Ht:	Wt:
Address:	City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's Name:		ID#:	Group#:
Allergies: □NKDA □ List Allergies:				

Clinical Information: please provide recent clinical notes, labs, and tests to expedite the prior authorization process

ICD-10 and Diagnosis:_____

Does patient have eosinophilic asthma?	□ Yes	□ No
Hx of asthma exacerbations requiring systemic corticosteroids?	□ Yes	□ No
Number of asthma related ED visit or hospitalization in past year?	□ 0 □ 1 □ 2+	
Dependent on daily systemic corticosteroid in addition to high dose inhaled corticosteroid?	□ Yes	□ No

	Baseline	Current
FEV_1 (% predicted)		
Asthma ACQ		
Asthma AQLQ		
Eosinophil Count		

Current Therapy:_____

Previous Failed Therapies:_____

_____

Prescription Information

Medication	Strength	Sig	Quantity	Refills
□ Auvi-Q	□ 0.1mg/0.1mL Autoinjector (7.5-15 kg) □ 0.15mg/0.15mL Autoinjector (15-30 kg) □ 0.3mg/0.3mL Autoinjector (≥ 30 kg)	□ Inject 1 injector IM into the outer thigh prn anaphylaxis. May repeat in 5 minutes if needed. Call 911. □	□ 1 Box □	
□ Dupixent	□ 200mg/1.14mL Prefilled Syringe □ 300mg/2mL Prefilled Syringe	Starter Dose: □ Inject 400mg (2 syringes) SC once □ Inject 600mg (2 syringes) SC once Maintenance Dose: □ Inject 200mg (1 syringe) SC every other week □ Inject 300mg (1 syringe) SC every other week	□ 1 month □	
□ Albuterol HFA	□ 90mcg/actuation	□ Inhale 2 puffs every 4 to 6 hours prn □	□ 1 inhaler □	
□	□	□		
□	□	□		
□	□	□		
□	□	□		

Prescriber Information				
Name:	Phone:		Office Contact Name:	
Address:		City:	State:	Zip:
NPI:	DEA:	Fax and/or Email:		
Prescriber Signature:		Date:	□ DO NOT SUBSTITUTE	

Sage Specialty Pharmacy – Phone: 414-861-7243 Fax: 414-906-0187 Address: 4001 N Oakland Ave Shorewood, WI 53211

I authorize Sage Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.