Mercy LTC & Specialty Pharmacy
A Member of Mercy Pharmacy Group

FAX: 562.402.4629

Pulmonology

Version: 04/03//2025

PATIENT INFORMATION

Patient Name: DOB: Patient Phone:

Allergies: Weight lbs/kg: Height:

DIAGNOSIS

Diagnosis/ICD 10:

Documentation

◯ Demographic info, H&P, insurance info, labs results, 2-3 clinical visit notes (as appropriate)

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	REFILLS
•Dupixent®	**•Dupixent Prefilled syringe** ◯ 300 mg/2 mL ◯ 200 mg/1.14 mL ◯ 100 mg/0.67 mL **•Dupixent Pen** ◯ 300 mg/2 mL ◯ 200 mg/1.14 mL	**INITIAL DOSE:** ◯ Inject 400 mg **SQ once** ◯ Inject 600 mg **SQ once** ◯ Other	**INITIAL DOSE (no refills):** ◯ 2 pens ◯ 2 prefilled syringes	
		MAINTENANCE DOSE: ◯ Inject 100 mg **SQ** every other week ◯ inject 200 mg **SQ** every other week ◯ inject 300 mg **SQ** every week ◯ inject 300 mg **SQ** every other week ◯ inject 300 mg **SQ** every 4 weeks ◯ **Other**	**MAINTENANCE DOSE:** ◯ ____ pens ◯ ____ prefilled syringes	
•Fasenra®	**•Fasenra®** ◯ 10 mg/0.5 prefilled syringe. ◯ 30 mg/mL prefilled syringe. ◯ 30 mg/mL PEN.	**INITIAL DOSE:** ◯ inject 10 mg **SQ** every 4 weeks for 3 doses ◯ inject 30 mg **SQ** every 4 weeks for 3 doses	**INITIAL DOSE (no refills):** ◯ 3 pens ◯ 3 prefilled syringes	
		MAINTENANCE DOSE: ◯ inject 10 mg **SQ** every 8 weeks ◯ inject 30 mg **SQ** every 8 weeks	**MAINTENANCE DOSE:** ◯ 1 pen ◯ 1 prefilled syringe	
XOLAIR®	XOLAIR® ◯ 150 mg Vial **OR** **Please choose** ◯ Pen ◯ Syringe ◯ 75 mg/0.5 mL ◯ 150 mg/mL ◯ 300 mg/2 mL	◯ Inject ___mg SC every ___week	◯ __ Vial ◯ __ Pen ◯ __ Syringe	
OTHER				

PROVIDER INFORMATION

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Provider/Practice Name: Contact Person:

Provider NPI: Phone: Fax:

Provider Signature **DAW (Dispense as Written)** **Date**

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