

# PALFORZIA UP-DOSE SHIPMENT REQUEST ORDER FORM

**NOTE: This optional form can be utilized with the patient's Specialty Pharmacy to request shipments to the CERTIFIED HEALTHCARE SETTING or the PATIENT'S HOME for doses beyond the Initial Dose Escalation (IDE), in lieu of a verbal shipment request. Shipment requests to a patient's home may require a call from Walgreens Specialty Pharmacy to verify delivery confirmation. This form is NOT a valid prescription and does NOT replace the PALFORZIA Prescription and Enrollment Form.**

This PALFORZIA Up-Dose Request Form can be used to communicate to the patient's Specialty Pharmacy that the following applies to the patient:

- An Up-Dosing appointment has been SCHEDULED and/or COMPLETED and THE DOSE LEVEL INDICATED BELOW SHOULD BE SHIPPED TO THE CERTIFIED HEALTHCARE SETTING or TO THE PATIENT'S HOME.
- If the patient has not completed toleration at the up-dose indicated for shipment, then the up-dose may only be sent directly to the CERTIFIED HEALTHCARE SETTING.

Shipment requests may be initiated by completing all required fields and faxing the PALFORZIA Up-Dose Request Form to the patient's Specialty Pharmacy at (866) 587-4476, and/or by calling Walgreens Specialty Pharmacies. A phone outreach to the certified healthcare setting by the Specialty Pharmacy to confirm or verify information may still be required. To ensure timely shipment of the product listed below, please complete **all required fields**, and allow for **up to 2 business days processing time before requested shipment date of product**.

## 1. Patient Information

Name (first, middle, last) \*

Date of birth (MM/DD/YYYY)\*

**Check Yes/No to the following questions for this patient:** Does this patient have any new known allergies?  
Does patient have injectable epinephrine that is not yet expired?

Yes  No

Yes  No

## 2. Prescriber Information

Provider Name (first, last)\*

Practice key contact name (first, last)\*

Practice key contact title

Practice contact phone #\*

Practice contact fax #

## 3. Up-Dosing Appointment Information & Shipment Request

**a) Indicate Dose Level to be shipped (check one)\***

- 3mg (level 1)    6mg (level 2)    12mg (level 3)    20mg (level 4)    40mg (level 5)    80mg (level 6)  
 120mg (level 7)    160mg (level 8)    200mg (level 9)    240mg (level 10)    300mg (15ct) (level 11)    300mg (30ct) (maintenance)

Check the box below if applicable:

This is a repeat dose and I have confirmed there are refills for this dose level on file

### b) Appointment Information

An Up-Dosing appointment has been SCHEDULED at the dose level indicated above and MUST be shipped to the CERTIFIED HEALTHCARE SETTING. If the patient has not completed toleration for the dose level indicated above, the dose may only be sent to the Certified Healthcare Setting.

Requested Shipment Arrival Date: MM/DD/YYYY (Shipment request date cannot be on a Saturday, Sunday or Monday)\*: \_\_\_\_\_

Business days/hours office accepts shipments\*: \_\_\_\_\_

Next Scheduled Patient Appointment Date\*: \_\_\_\_\_

### b1) Shipment Information for the CERTIFIED HEALTHCARE SETTING

Address\*

City\*

State\*

Zipcode\*

### c) Toleration Confirmation

Patient toleration of the Up-Dose level requested for shipment indicated above must be COMPLETED by the patient and CONFIRMED by the Provider and/or Provider Representative in order to request shipment to the PATIENT'S HOME. By requesting shipment to the PATIENT'S HOME, it is understood that the Specialty Pharmacy may contact the HEALTH CARE SETTING to confirm tolerability, and may contact the patient to confirm delivery.

Name of Provider or Provider Representative confirming dose toleration \*: \_\_\_\_\_

If Provider Representative, title of Provider Representative giving dose toleration confirmation\*: \_\_\_\_\_

Date of Toleration Confirmed\*: \_\_\_\_\_

Strength of Up-Dose Level Tolerated\* \_\_\_\_\_

### c1) Shipment Information for the PATIENT HOME

Address\*

City\*

State\*

Zipcode\*

## 5. Specialty Pharmacy filling prescription (check one)\*

Walgreens Community-Based Specialty Pharmacies  
Phone: (800)-445-3674   Fax: (866)-587-4476

AllianceRx-Walgreens Specialty Pharmacy  
Phone: (888) 347-3416   Fax: (866)-587-4476

Please fax this completed PALFORZIA Up-Dose Shipment Request Form to the selected Walgreens Specialty Pharmacy of choice at the fax number listed above. Alternatively, you may request shipment verbally by calling the preferred Walgreens Specialty Pharmacy.

By checking this box, I certify the information provided on this form is accurate\*

Name of person completing this form\*

Title of person completing this form\*

Date (MM/DD/YYYY)\*