Auvi-Q®
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

Direct Delivery Service Patient Enrollment Form

Customer Service: **(844) 357-3968**
Fax completed form to: **(877) 397-7479**

*Indicates required field

PATIENT INFORMATION

*Patient Name (Last, First):

*Date of Birth: Gender: M ☐ F ☐

*Address: *(Cannot be a PO Box)*

*City: *State: *Zip:

*Cell: *Home Phone:

*Email: *SSN (last 4 digits):

Emergency contact: Phone #:

PRESCRIPTION INFORMATION

*Patient Name (Last, First):

Drug: **AUVI-Q® (epinephrine injection, USP)** ☐ 0.15 mg ☐ 0.3 mg

*Date: Refills:

*Quantity:
☐ 1 (one) Carton (2 (two) auto-injectors and 1 (one) Trainer)
☐ 2 (two) Cartons (4 (four) auto-injectors and 2 (two) Trainers)

*Sig (Directions): PRN For severe allergic reactions, including anaphylaxis, as directed

*Delivery Options:
☐ Deliver to Patient's Home
☐ Deliver to Prescriber's Office

PROVIDER ATTESTATION

By signing below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that ASPN Pharmacies, LLC "ASPN" reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

*Prescriber's Signature

Signature is required to process the prescription.
Stamped signatures are not permissible.
(Dispense As Written)

*Date of Signature

PRIMARY PRESCRIPTION INSURANCE

(1) Fill in fields with pharmacy insurance information (NOT medical), OR
(2) Fax patient demographic information or patient insurance card along with enrollment form.

*Insurance Name: Pharmacy Help Desk Phone #:

Policyholder Name: *Relationship to Patient:

*Member ID: *Group ID:

*Rx BIN: *PCN:

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

*NPI:

*Prescriber's Primary Specialty: ☐ **Allergy** ☐ **Pediatrics** ☐ **Other**

*Prescriber Phone: *Fax:

*Address:

*City: *State: *Zip:

Email:

*Tax ID: *DEA:

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (Last, First):

*Email: *Phone:

CLINICAL INFORMATION

*Diagnosis:

History of, or at risk for, severe allergic reaction to:

☐ Food ☐ Insect venom ☐ Medications ☐ Idiopathic
☐ Other

kaléo® | Auvi-Q epinephrine injection, USP 0.15 mg/0.3 mg auto-injectors
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See Indication and Important Safety Information on reverse.
Please see full Prescribing Information at www.auvi-q.com.