Palforzia®
Peanut (*Arachis hypogaea*) Allergen Powder-dnfp

*Required field

PALFORZIA UP-DOSE SHIPMENT REQUEST ORDER FORM

NOTE: This optional form can be utilized with the 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 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) 773-0143, and/or by calling Walgreens Specialty Pharmacy at (800) 445-3674. 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? Yes ☐ No ☐

Does patient have injectable epinephrine that is not yet expired? 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)*

☐ 1mg (level 0) ***(ONLY for 1 through 3 years old)*** ☐ 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) ☐ 300mg (90ct) (maintenance) *per insurance approval*

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* _____ Zip code* _____

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* _____ Zip code* _____

4. Specialty Pharmacy filling prescription (check one)*

☐ Walgreens Specialty Pharmacy (Central) Phone: (800) 445-3674 Fax: (866) 773-0143

☐ Walgreens Specialty Pharmacy (Community) _____ Phone: (800) 445-3674 Fax: (866) 773-0143

Please fax this completed PALFORZIA Up-Dose Shipment Request Form to Walgreens Specialty Pharmacy at the fax number listed above. Alternatively, you may request shipment verbally by calling Walgreens Specialty Pharmacy. Please allow up for up to 2 business days for processing time before requested shipment date of product.

☐ 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)* _____