

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____	ID: _____	Group: _____
Secondary Insurance: _____	ID: _____	Group: _____
Prescription Card: _____	ID: _____	BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS	MEDICAL HISTORY
☐ L50 Urticaria ☐ L50.0 Allergic urticaria ☐ L50.1 Idiopathic urticaria ☐ L50.2 Urticaria due to cold and heat ☐ L50.3 Dermatographic urticaria ☐ L50.4 Vibratory urticaria ☐ L50.5 Cholinergic urticaria ☐ L50.6 Contact urticaria ☐ L50.8 Other urticaria ☐ L50.9 Urticaria, unspecified	Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in Allergies: _____ Line Access: ☐ PIV ☐ Midline ☐ PICC ☐ Port ☐ Other: _____ Therapy Start Date: _____ Therapy End Date: _____ Nursing Coordination: ☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No ☐ Home health nursing coordination not necessary. Reason: ☐ MD office to administer to patient ☐ Home health nursing already coordinated
☐ Patient demographics, including insurance information ☐ Include original prescription orders ☐ Clinical/Progress notes with supporting diagnosis ☐ H&P	

PRESCRIPTION INFORMATION

Quzyttir®:	Dose:	Directions:	Quantity:	Refills:
☐ Adults and adolescents >12 years old	☐ 10mg	☐ Slow intravenous push over 1-2 minutes once every 24 hours as needed ☐ Other: _____		
☐ Children 6 to 11 years old	☐ 5mg ☐ 10mg			
☐ Children 6 months to 5 years old	☐ 2.5mg			
***QUZYTIR® is not recommended in pediatric patients less than 6 years of age with impaired renal or hepatic function				

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol ☐ NaCl 0.9% 5mL ☐ NaCl 0.9% 10mL	☐ Heparin 10 units per mL ☐ Heparin 100 units per mL ☐ Other: _____
Premedications & Other Medications ☐ Infusion supplies as per protocol ☐ Anaphylaxis Kit orders as per protocol	☐ Acetaminophen _____ mg PO prior to infusion ☐ Diphenhydramine _____ mg PO

ADDITIONAL COMMENTS:

Prescriber Signature: _____ Date: _____

