HERITAGE BIOLOGICS

Injectable Biologics Patient Referral Form

Admissions Fax # 844-878-6917 Phone# 855-WE-R-RARE (855-937-7273)

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	

Additional Documentation Needed

❁ Copy of insurance cards ❁ History and Physical with patient demographics ❁ Recent vitals including blood pressure

Patient Insurance Information

Insurance Plan #1		Insurance Plan #2	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender	Height (in.)	Weight (lbs)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:

Medication Information/Prescription and Orders

Medication:	Dose and Directions	
□ Fasenra (benralizumab)	□ 30 mg/mL single dose autoinjector pen	□ Initial Dose: 30 mg SQ every 4 weeks X 3 doses + 0 refills □ Maintenance Dose: 30 mg SQ every 8 weeks thereafter
□ Nucala (mepolizumab)	□ 40 mg/0.4mL single dose prefilled syringe □ 100 mg/mL single dose prefilled syringe □ 100mg/mL prefilled autoinjector	□ Severe Asthma (≥12 yrs): 100 mg SQ every 4 weeks □ Severe Asthma (6-11 yrs): 40 mg SQ every 4 weeks □ CRSwNP: 100 mg SQ every 4 weeks □ EGPA: 300 mg (3 separate 100 mg injections) SQ every 4 weeks □ HES: 300 mg (3 separate 100 mg injections) SQ every 4 weeks
□ Xolair (Omalizumab)	□ 75 mg/0.5 mL pre-filled syringe □ 150 mg/mL pre-filled syringe	□ Asthma: _____ mg SQ every 2 weeks OR _____ mg SQ every 4 weeks □ Chronic Rhinosinusitis with Nasal Polyps: _____ mg SQ every 2 weeks OR _____ mg SQ every 4 weeks □ Chronic Spontaneous Uritcaria: _____ mg SQ every 4 weeks
□ Dupxient (Dupliumab)	□ 100 mg/0.67 mL pre-filled syringe □ 200 mg/1.14 mL pre-filled syringe □ 300 mg/2 mL pre-filled syringe □ 200 mg/1.14 mL pre-filled pen □ 300 mg/2 mL pre-filled pen	□ Atopic Dermatitis (Adults): Loading dose - 600 mg (2- 300 mg injections) SQ X 1 Maintenance dose - 300 mg SQ every other week □ Atopic Dermatitis (Peds 6 mths-5 yrs -- 5-14 kg): 200 mg SQ every 4 weeks □ Atopic Dermatitis (Peds 6 mths-5 yrs -- 15-30 kg): 300 mg SQ every 4 weeks □ Atopic Dermatitis (Peds 6-17 yrs -- 15-29 kg): Loading dose - 600 mg (2-300 mg injections) SQ X1 Maintenance dose - 300 mg SQ every 4 weeks □ Atopic Dermatitis (Peds 6-17 yrs -- 30-59 kg): Loading dose - 400 mg (2-200 mg injections) SQ X1 Maintenance dose - 200 mg SQ every 2 weeks □ Atopic Dermatitis (Peds 6-17 yrs -- 60 kg+): Loading dose - 600 mg (2-300 mg injections) SQ X1 Maintenance dose - 300 mg SQ every 2 weeks □ Asthma (Adults & Peds ≥12 yrs): Loading dose - 400 mg (2-200 mg injections) SQ X1 Maintenance dose - 200 mg SQ every 2 weeks □ Asthma (Adults & Peds ≥12 yrs): Loading dose - 600 mg (2-300 mg injections) SQ X1 Maintenance dose - 300 mg SQ every 2 weeks □ Asthma (Peds 6-11 yrs; 15-29kg): 100 mg SQ every other week □ Asthma (Peds 6-11 yrs; 15-29kg): 300 mg SQ every 4 weeks □ Asthma (Peds 6-11 yrs; 30kg+): 200 mg SQ every other week □ Other: 300 mg SQ every other week □ Other: Loading dose - _____ mg SQ X1 Maintenance dose - _____ mg SQ every ____ week(s)

Quantity/Refills

Dispense Quanity #QS + 1 year of refills unless otherwise noted

*If subsequent treatment only
Date of last injection_____ Next dose due _____

❁ Severe reaction (w/breathing problems): CALL 911, administer Epinephrine 0.3 mg IM or 0.15 mg, #2**(as determined by patient weight)**

Prescriber Information

Physician Name	Office Contact	NPI#	DEA#
Practice Address		Practice Phone	

Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date