



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)
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Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:
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Medication Information/Prescription and Orders

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

Quantity/Refills

Dispense Quantity #QS + 1 year of refills unless otherwise noted	*If subsequent treatment only Date of last injection _____ Next dose due _____
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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