

Injectable Biologics Patient Referral Form

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

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:	Dosage Form:	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 pre-filled syringe <input type="checkbox"/> 100 mg/mL single dose pre-filled syringe <input type="checkbox"/> 100mg/mL pre-filled 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 (Duplumab)	<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	<p>Asthma:</p> <p>Adults & Peds ≥12 yr: <input type="checkbox"/> Loading dose: 400 mg (2-200 mg injections) SQ X1 Maintenance dose: 200 mg SQ every 2 weeks <input type="checkbox"/> Loading dose: 600 mg (2-300 mg injections) SQ X1 Maintenance dose: 300 mg SQ every 2 weeks</p> <p>Peds <12yr: <input type="checkbox"/> 6-11 yr (15-29kg): 100 mg SQ every other week <input type="checkbox"/> 6-11 yr (15-29kg): 300 mg SQ every 4 weeks <input type="checkbox"/> 6-11 yr (≥30kg): 200 mg SQ every other week</p> <p>Eosinophilic Esophagitis:</p> <input type="checkbox"/> Adults & Peds ≥1yr (≥40kg): 300 mg SQ every week <input type="checkbox"/> Peds ≥1yr (30-39kg): 300 mg SQ every other week <input type="checkbox"/> Peds ≥1yr (15-29kg): 200 mg SQ every other week <p>Atopic Dermatitis:</p> <p>Adults: <input type="checkbox"/> Loading dose: 600 mg (2- 300 mg injections) SQ X 1; Maintenance dose: 300 mg SQ every other week</p> <p>Peds: <input type="checkbox"/> 6 mo-5 yr (5-14 kg): 200 mg SQ every 4 weeks <input type="checkbox"/> 6 mo-5 yr (15-30 kg): 300 mg SQ every 4 weeks <input type="checkbox"/> 6-17 yr (15-29 kg): Loading dose: 600 mg (2-300 mg injs) SQ X1; Maintenance dose: 300 mg SQ every 4 weeks <input type="checkbox"/> 6-17 yr (30-59 kg): Loading dose: 400 mg (2-200 mg injs) SQ X1; Maintenance dose: 200 mg SQ every 2 weeks <input type="checkbox"/> 6-17 yr (≥60 kg): Loading dose: 600 mg (2-300 mg injs) SQ X1; Maintenance dose: 300 mg SQ every 2 weeks</p> <p>Other:</p> <input type="checkbox"/> 300 mg SQ every other week <input type="checkbox"/> 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 (as determined by patient weight). Dispense Quantity #QS + 1 year of refills

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