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	
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 ☐ M ☐ F	Height (in.)	Weight (lbs)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:

Medication Information/Prescription and Orders

Medication:	Dosage Form:	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	
☐ Dupixent (Dupilumab)	☐ 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	Asthma: Adults & Peds ≥12 yr: ☐ Loading dose: 400 mg (2-200 mg injections) SQ X1 Maintenance dose: 200 mg SQ every 2 weeks ☐ Loading dose: 600 mg (2-300 mg injections) SQ X1 Maintenance dose: 300 mg SQ every 2 weeks Peds <12yr: ☐ 6-11 yr (15-29kg): 100 mg SQ every other week ☐ 6-11 yr (15-29kg): 300 mg SQ every 4 weeks ☐ 6-11 yr (≥30kg): 200 mg SQ every other week	Atopic Dermatitis: Adults: ☐ Loading dose: 600 mg (2- 300 mg injections) SQ X 1; Maintenance dose: 300 mg SQ every other week Peds: ☐ 6 mo-5 yr (5-14 kg): 200 mg SQ every 4 weeks ☐ 6 mo-5 yr (15-30 kg): 300 mg SQ every 4 weeks ☐ 6-17 yr (15-29 kg): Loading dose: 600 mg (2-300 mg injs) SQ X1; Maintenance dose: 300 mg SQ every 4 weeks ☐ 6-17 yr (30-59 kg): Loading dose: 400 mg (2-200 mg injs) SQ X1; Maintenance dose: 200 mg SQ every 2 weeks ☐ 6-17 yr (≥60 kg): Loading dose: 600 mg (2-300 mg injs) SQ X1; Maintenance dose: 300 mg SQ every 2 weeks
		Eosinophilic Esophagitis: ☐ Adults & Peds ≥1yr (≥40kg): 300 mg SQ every week ☐ Peds ≥1yr (30-39kg): 300 mg SQ every other week ☐ Peds ≥1yr (15-29kg): 200 mg SQ every other week	Other: ☐ 300 mg SQ every other week ☐ 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 **(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