Injectable Biologics Pediatric 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)

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 □ 10 mg/0.5 mL single dose prefilled syringe	<u>Peds 6-12yr & ≥ 35kg, and Peds ≥ 12yo:</u> □ Severe Eosinophilic Asthma: 30 mg SubQ every 4 weeks X 3 doses, then every 8 weeks thereafter □ Eosinophilic Granulomatosis w/ Polyangiitis: 30 mg SubQ every 4 weeks <u>Peds 6-12yr & < 35kg</u> □ Eosinophilic Asthma, Add-On Maintenance: 10 mg SubQ every 4 weeks X 3 doses, then every 8 weeks thereafter
□ Nucala (mepolizumab)	□ 40 mg/0.4mL prefilled syringe □ 100 mg/mL prefilled syringe □ 100mg/mL prefilled autoinjector	□ Severe Asthma (6-11 yrs): 40 mg SubQ every 4 weeks □ Chronic Rhinosinusitis w/ Nasal Polyps (CRwNP): 100 mg SubQ every 4 weeks □ Eosinophilic Granulomatosis w/ Polyangiitis: 300 mg (3 separate 100 mg injections) SubQ every 4 weeks □ Hypereosinophilic Syndrome: 300 mg (3 separate 100 mg injections) SubQ every 4 weeks
□ Xolair (omalizumab)	□ 75 mg/0.5 mL □ prefilled syringe □ 150 mg/1 mL □ 300 mg/2 mL □ autoinjector	□ Asthma: _____ mg SubQ every 2 weeks OR _____ mg SubQ every 4 weeks □ Chronic Rhinosinusitis with Nasal Polyps: _____ mg SubQ every 2 weeks OR _____ mg SubQ every 4 weeks □ Chronic Spontaneous Urticaria: _____ mg SubQ every 4 weeks □ IgE-Mediated Food Allergy: _____ mg SubQ every 4 weeks OR _____ mg SubQ every 2 weeks
□ Dupixent (dupilumab)	□ 200 mg/1.14 mL prefilled syringe □ 300 mg/2 mL prefilled syringe □ 200 mg/1.14 mL prefilled pen □ 300 mg/2 mL prefilled pen	Asthma: □ 6-11 yr (15-29kg): 300 mg SubQ every 4 weeks □ 6-11 yr (≥30kg): 200 mg SubQ every other week Atopic Dermatitis □ 6 mo-5 yr (5-14 kg): 200 mg SubQ every 4 weeks □ 6 mo-5 yr (15-30 kg): 300 mg SubQ every 4 weeks □ 6-17 yr (15-29 kg): Loading dose: 600 mg (2-300 mg injs) SubQ X1; Maintenance dose: 300 mg SubQ every 4 weeks □ 6-17 yr (30-59 kg): Loading dose: 400 mg (2-200 mg injs) SubQ X1; Maintenance dose: 200 mg SubQ every 2 weeks □ 6-17 yr (≥60 kg): Loading dose: 600 mg (2-300 mg injs) SubQ X1; Maintenance dose: 300 mg SubQ every 2 weeks Eosinophilic Esophagitis: □ Peds ≥1yr (30-39kg): 300 mg SubQ every other week □ Peds ≥1yr (15-29kg): 200 mg SubQ every other week Other: □ Refractory COPD: 300 mg SubQ every other week □ CRwNP: 300 mg SubQ every other week □ Prurigo Nodularis: 600 mg SubQ X 1, then 300 mg every other week

Quantity/Refills

Dispense Quantity #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

Prescriber Name	Office Contact	NPI#	License#
Practice Address		Practice Phone	Practice Fax

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