BioTek reMEDys
www.Biotekrx.com

Asthma Treatments Referral Form

2 Penns Way, Ste#404
New Castle, DE 19720
Phone: (877) 246-9104
Fax: (800) 783-9146

PATIENT INFORMATION (Complete or fax existing chart)

Patient Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ 2nd Phone: _____
DOB: _____ Gender: M F Last 4 S.S:_____
Weight: Ht: Allergies:

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____ NPI #: _____
DEA: _____ Phone: _____
Address: _____Fax: _____
City, State, Zip:_____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION - INSTEAD - just send us a copy of the patients prescription / insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____
Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____ _
City, State, Zip: _____
Group #: _____
Phone: _____

DIAGNOSIS /CLINICAL INFORMATION

☐ J45.40 Moderate Persistent Asthma, Uncomplicated	☐ M30.1 Polyarteritis with lung involvement [Churg-Strauss]
☐ J45.50 Severe persistent asthma, uncomplicated	☐ J33.9 Nasal Polyps, Unspecified ☐ J33.0 Polyp of Nasal Cavity
☐ J45.51 Severe persistent asthma with (acute) exacerbation	☐ L50.1 Idiopathic urticaria
Eosinophil Count: _____ cells/µL Date of Test:	☐ Other:

Needs by Date: Ship to: Patient Office Other:
Lab Orders:

Fasenra

☐ FASENRA® (benralizumab) 30 mg/mL single-dose prefilled syringe (administered by healthcare professional)
☐FASENRA Pen™ (benralizumab) 30 mg/mL single-dose autoinjector (Self administered)

☐ Loading Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 4 weeks for 3 doses QTY: ___Refills: ___
☐ Maintenance Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 8 weeks – QTY: ___ Refills:____

Nucala

☐ Prefilled syringe ☐ Vial ☐ Pen
☐ Inject 100 mg subcutaneously once every 4 weeks
☐ Inject 300 mg (3 separate 100 mg injections) subcutaneously once every 4 weeks
☐ Inject _____ mg (__ separate 100 mg injections) subcutaneously once every __ weeks

Dupixent Pre-filled syringe, package of 2

☐Initial dose: 400 mg SIG: 2 (200 mg/1.14 mL) injections SQ on Day 1
Subsequent (maintenance) dose: 200 mg
SIG: 1 (200 mg/1.14 mL) injection SQ every 2 weeks, starting on Day 15

☐ Initial dose: 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
Subsequent (maintenance) dose: 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15

Other: Initial: _____ Subsequent: Dose_____ Frequency_____
QTY: ___ pk (2 syringes) Refills_____

Xolair

☐ Prefilled syringe ☐ Vial Prescription Type: ☐ New start ☐ Restart ☐ Continued Tx Last injection date:_____

SIG ☐ 75 mg/dose every 4 weeks
SIG ☐ 150 mg/dose every 4 weeks
SIG ☐ 225 mg/dose every 4 weeks
SIG ☐ 300 mg/dose every 4 weeks
SIG ☐ 225 mg/dose every 2 weeks
SIG ☐ 300 mg/dose every 2 weeks
SIG ☐ 375 mg/dose every 2 weeks

SIGNATURE

We hereby authorize Biotek Remedys to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X _____ Date: _____
Product Substitution Permitted

Fax completed form to: (800) 783-9146 Thank you for using BioTek reMEDys