



ASTHMA TREATMENTS

Please Fax Completed Form To: 800-783-9146

PATIENT INFORMATION (Complete or Fax Existing Chart) PRESCRIBER INFORMATION

Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____
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INSURANCE INFORMATION – OR – Send a copy of the patient’s prescription/insurance cards (front & back)

Primary Insurance: _____ City, State, Zip: _____ Plan #: _____ Group #: _____ Phone: _____	RX Card (PBM): _____ BIN: _____ PCN: _____ City, State, Zip: _____ Group #: _____ Phone: _____
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CLINICAL INFORMATION

<input type="checkbox"/> J45.40 Moderate persistent asthma, uncomplicated	<input type="checkbox"/> M30.1 Polyarteritis with lung involvement [Churg-Strauss]
<input type="checkbox"/> J45.50 Severe persistent asthma, uncomplicated	<input type="checkbox"/> J33.9 Nasal Polyps, unspecified <input type="checkbox"/> J33.0 Polyp of Nasal Cavity
<input type="checkbox"/> J45.51 Severe persistent asthma with (acute) exacerbation	<input type="checkbox"/> L50.1 Idiopathic urticaria
Eosinophil Count: _____ cells/ μ L Date of Test: _____	<input type="checkbox"/> Other: _____

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

FASENRA

<input type="checkbox"/> FASENRA® (benralizumab) 30 mg/mL single-dose prefilled syringe (administered by healthcare professional) <input type="checkbox"/> FASENRA Pen™ (benralizumab) 30 mg/mL single-dose autoinjector (Self administered)	<input type="checkbox"/> Loading Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 4 weeks for 3 doses QTY: _____ Refills: _____ <input type="checkbox"/> Maintenance Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 8 weeks – QTY: _____ Refills: _____
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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

<input type="checkbox"/> 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 Other: Initial: _____ Subsequent: Dose _____ Frequency _____	<input type="checkbox"/> 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

<input type="checkbox"/> Prefilled syringe <input type="checkbox"/> Vial SIG <input type="checkbox"/> 75 mg/dose every 4 weeks SIG <input type="checkbox"/> 150 mg/dose every 4 weeks SIG <input type="checkbox"/> 225 mg/dose every 2 weeks SIG <input type="checkbox"/> 375 mg/dose every 2 weeks	Prescription Type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued Tx SIG <input type="checkbox"/> 150 mg/dose every 4 weeks SIG <input type="checkbox"/> 225 mg/dose every 2 weeks	Last injection date: _____ SIG <input type="checkbox"/> 225 mg/dose every 4 weeks SIG <input type="checkbox"/> SIG <input type="checkbox"/> 300 mg/dose every 2 weeks
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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: _____

Prescriber Signature

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