ASTHMA TREATMENTS

Please Fax Completed Form To: 800-783-9146

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

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: _____

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
Other: Initial: _____

□ 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
Subsequent: Dose_____ Frequency

QTY: _____ pk (2 syringes) Refills

XOLAIR

☐ Prefilled syringe □ Vial
SIG □ 75 mg/dose every 4 weeks
300 mg/dose every 4 weeks
SIG □ 375 mg/dose every 2 weeks

Prescription Type: □ New start □ Restart □ Continued Tx
SIG □ 150 mg/dose every 4 weeks
SIG □ 225 mg/dose every 2 weeks

Last injection date:_____
SIG □ 225 mg/dose every 4 weeks SIG □
SIG □ 300 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: _____
Prescriber Signature