BioPlus® Specialty Pharmacy
A Carelon Company

Immunology

Fax: 800-269-5493 Phone: 888-292-0744 bioplusrx.com

Need By Date: _____ Ship To: ☐Patient ☐Office ☐Other _____ Fax Copy: ☐Rx Card Front/Back ☐Clinical Notes ☐Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐Female ☐Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ J45.40 Moderate Asthma ☐ J45.50 Severe Asthma ☐ L20.9 Atopic Dermatitis ☐ L50.1 Chronic Idiopathic Urticaria (CIU) ☐ J33 Chronic Rhinosinusitis with Nasal Polyposis ☐ Other: _____ Dx Code: _____ | Eosinophil Levels

Concomitant Therapies: ☐ Short-acting Beta Agonist ☐ Long-acting Beta Agonist ☐ Antihistamines ☐ Decongestants ☐ Immunotherapy ☐ Inhaled Corticosteroid ☐ Leukotriene Modifiers ☐ Oral Steroids ☐ Nasal Steroids ☐Other: _____

Please List Therapies	Weight ☐ kg ☐ lbs	Date Weight Obtained

Lab Results: ☐ History of positive skin OR RAST test to a perennial aeroallergen
Pretreatment Serum IgE Level: _____ IU per mL Test Date: _____ / _____ / _____

MD Specialty: ☐ Allergist ☐ Dermatologist ☐ ENT ☐ Pediatrician ☐ Primary Care ☐ Pulmonologist ☐ Other: _____

Prescription Type: ☐ Naïve/New Start ☐ Restart ☐ Continued Therapy
Last Injection Date: _____ / _____ / _____

Drug Allergies | Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Dupixent®	200 mg ☐ Pen ☐ PFS w/Shield ☐ Asthma ☐ Atopic Dermatitis	☐ Load: Inject 400 mg (as two-200 mg injections in different sites) on Day 1, then inject 200 mg every other week starting on Day 15 ☐ Maintenance: Inject 200 mg SUBQ every other week	2 Syringes 2 Syringes	None _____
	300 mg ☐ Pen ☐ PFS w/Shield ☐ Asthma ☐ Atopic Dermatitis	☐ Load: Inject 600 mg (as two-300 mg injections in different sites) on Day 1, then inject 300 mg every other week starting on Day 15 ☐ Maintenance: Inject 300 mg SUBQ every other week	2 Syringes 2 Syringes	None _____
	300 mg ☐ Pen ☐ PFS w/Shield ☐ Chronic Rhinosinusitis with Nasal Polyposis	Inject 300 mg SUBQ every other week	2 Syringes	_____
☐ Fasenra®		Fax completed Fasenra Access 360™ Enrollment Form to BioPlus Specialty Pharmacy at 800-269-5493		
☐ Nucala®	☐ 100 mg Pre-filled Auto-injector ☐ 100 mg PFS ☐ 100 mg Vial* *Supplies dispensed: One 10 mL vial sterile water for injection for every Nucala vial dispensed, alcohol swabs, 3 mL Luer Lock inj syringe, 21 G NDL for reconstitution, 1 mL polypropylene syringe with 21 G to 27 G x 1/2" NDL for subcutaneous injection ☐ No supplies requested (supplies will be sent with shipment unless indicated)	☐ **Patients with Asthma** Inject 100 mg SUBQ once every 4 weeks ☐ **Patients with EGPA** Inject 300 mg (3-100 mg injections) SUBQ once every 4 weeks	28 Day Supply 28 Day Supply	_____ _____
☐ Xolair®	75 mg ☐ PFS ☐ Autoinjector 150 mg ☐ PFS ☐ Autoinjector ☐Vial* 300 mg ☐ PFS ☐ Autoinjector *Supplies dispensed: One 10 mL sterile water for injection for every Xolair vial dispensed, alcohol swabs, 3 mL Luer Lock inj syringe, 18 G x 1 1/2" Safety Glide NDL for reconstitution, 25 G x 5/8" Safety Glide NDL for subcutaneous injection ☐ No supplies requested (supplies will be sent with shipment unless indicated)	**Patients with Asthma** ☐ Inject 75 mg SUBQ once every 4 weeks ☐ Inject 150 mg SUBQ once every 4 weeks ☐ Inject 225 mg SUBQ once every 2 weeks ☐ Inject 225 mg SUBQ once every 4 weeks ☐ Inject 300 mg SUBQ once every 2 weeks ☐ Inject 300 mg SUBQ once every 4 weeks ☐ Inject 375 mg SUBQ once every 2 weeks **Patients with CIU** ☐ Inject 150 mg SUBQ once every 4 weeks ☐ Inject 300 mg SUBQ once every 4 weeks	28 Day Supply	_____
☐ EpiPen® (Injection)	0.3 mg/0.3 mL Pre-filled Auto-injector	Inject EpiPen® 0.3 mg intramuscularly or SUBQ in patients greater than or equal to 30 kg (66 lbs)	2	0
☐ EpiPen®**Jr** (Injection)	0.15 mg/0.3 mL Pre-filled Auto-injector	Inject EpiPen®**Jr** 0.15 mg intramuscularly or SUBQ in patients 15 to 30 kg (33 lbs to 66 lbs)	2	0
☐ Other				

Prescriber's Signature (no stamps) **Substitution Permitted** **Date**

Prescriber's Signature (no stamps) **Dispense As Written** **Date**