Zarina Pharmacy
SPECIALTY & INFUSION

Immunology

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.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				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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

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