Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select BioPlus from your EHR!

Pulmonary (A-M)

Phone: 832-886-4296 **Fax:** 832-886-4298 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
SSN	
Date of Birth	☐ Female ☐ Male

Prescriber Information

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

Clinical Information

Primary Diagnosis	**ICD-10** ***(Required)***	Secondary Diagnosis	**ICD-10** ***(Required)***
Current Medications			
Tried/Failed Medications		Number of Exacerbations in the Last 12 Months	

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

MD Specialty: ☐ Pulmonologist ☐ Infectious Disease ☐ Other: _____	Prescription Type: ☐ Naïve/New Start ☐ Restart ☐ Continued Therapy Last Injection Date: _____ / _____ / _____
Drug Allergies	Weight ☐ kg ☐ lbs Height ☐ ft ☐ in

Prescription Information

			Qty	Refills
☐ Dupixent® *(dupilumab)*	☐ 200mg/1.14mL PFS ☐ 200mg/1.14mL Pen ☐ 300mg/2mL PFS ☐ 300mg/2mL Pen	**Asthma:** ☐ Induction: ☐ Inject 400mg SUBQ for first dose **OR** ☐ Inject 600mg SUBQ for first dose ☐ Maintenance: ☐ Inject 200mg SUBQ every other week **OR** ☐ Inject 300mg SUBQ every other week **COPD (Chronic Bronchitis or Emphysema):** ☐ Inject 300mg SUBQ every other week Please complete Dupixent MyWay™ Enrollment Form and fax to BioPlus Specialty Pharmacy at 800-269-5493	2 for 14 days 2 for 14 days 2 for 28 days 2 for 28 days	0 0 _____ _____
☐ Esbriet® *(pirfenidone)*	☐ 267mg Capsule ☐ 267mg Tablet ☐ 801mg Tablet	☐ Initial 14 Day Titration: Days 1-7: Take 1 tablet/capsule (267mg) PO three times daily with food Days 8-14: Take 2 tablets/capsules (534mg) PO three times daily with food Days 15+: Take 3 tablets/capsules (801mg) PO three times daily with food ☐ Maintenance: Take 801mg PO three times daily with food	_____ _____	_____ _____
☐ Fasenra® *(benralizumab)*	☐ 10mg/0.5mL PFS ☐ 30mg/mL PFS ☐ 30mg/mL Pen	**Asthma:** ☐ Induction: Inject 30mg SUBQ every 4 weeks for 3 doses ☐ Maintenance: Inject 30mg SUBQ every 8 weeks **Eosinophilic Granulomatosis with Polyangiitis (EGPA):** ☐ Inject 30mg SUBQ every 4 weeks	1 1 1	2 _____ _____
☐ 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 payors 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**

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MD Specialty: ☐ Pulmonologist ☐ Infectious Disease ☐ Other: _____	Prescription Type: ☐ Naïve/New Start ☐ Restart ☐ Continued Therapy Last Injection Date: _____ / _____ / _____
Drug Allergies	Weight ☐ kg ☐ lbs Height ☐ ft ☐ in

Prescription Information

			Qty	Refills
☐ Nintedanib Esylate	☐ 100mg Capsule ☐ 150mg Capsule	☐ Take 1 capsule PO twice daily with food, approximately 12 hours apart	_____	_____
☐ Nucala® *(mepolizumab)*	☐ 100mg Vial ☐ 100mg/mL PFS ☐ 100mg/mL Pen ☐ Sterile Water for Injection 10mL Vial	**Asthma/COPD (Chronic Bronchitis or Emphysema):** ☐ Inject 100mg SUBQ once every 4 weeks **Eosinophilic Granulomatosis with Polyangiitis (EGPA):** ☐ Inject 300mg (3 x 100mg) SUBQ once every 4 weeks	1 3 QS	_____ _____ _____
☐ Macitentan	☐ 10mg Tablet	☐ Take 1 tablet PO once daily	_____	_____
☐ Pulmozyme® *(dornase alfa)*	☐ 2.5mg/2.5mL Ampule	☐ Inhale 1 ampule via nebulizer once daily ☐ Inhale 1 ampule via nebulizer twice daily	30 60	_____ _____
☐ Tezspire® *(tezepelumab-ekko)*	☐ 210mg/1.91mL PFS ☐ 210mg/1.91mL Pen	☐ Inject 210mg SUBQ once every 4 weeks	1	_____
☐ Tobramycin Inhalation Solution	☐ 300mg/4mL Ampule ☐ 300mg/5mL Ampule	☐ Inhale 1 vial via nebulizer twice daily for 28 days on and 28 days off	56	_____
☐ Tobi® Podhaler® *(tobramycin)*	☐ 28mg Capsule for Inhalation	☐ Inhale the contents of 4 capsules via podhaler twice daily x 28 days on and 28 days off	224	_____
☐ Xolair® *(omalizumab)*	☐ 150mg Vial ☐ 75mg/0.5mL PFS ☐ 75mg/0.5mL Pen ☐ 150mg/mL PFS ☐ 150mg/mL Pen ☐ 300mg/2mL PFS ☐ 300mg/2mL Pen ☐ Sterile Water for Injection 10mL Vial	☐ Inject 225mg SUBQ once every 2 weeks ☐ Inject 300mg SUBQ once every 2 weeks ☐ Inject 375mg SUBQ once every 2 weeks ☐ Inject 150mg SUBQ once every 4 weeks ☐ Inject 300mg SUBQ once every 4 weeks	28 Day Supply QS	_____ _____
☐ 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 payors 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.

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