BioPlus® Specialty Pharmacy
A Carelon Company

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

PULMONARY

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

PATIENT INFORMATION

Name:	SSN:		DOB:
Address:	City:	State:	ZIP:
Home Phone: / Cell:	Email:		Gender: ○ Female ○ Male

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION

Primary Diagnosis (ICD-10): | Secondary Diagnosis (ICD-10):

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: | Height: | Weight:

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

MD Specialty: ☐ Pulmonologist: ☐ Infectious Disease: ☐ Other: _____ | Prescription Type: ☐ Naive/New Start ☐ Restart ☐ Continued Therapy | Last Injection Date: ___/___/___

Drug Allergies: | Status: ☐ New ☐ Restart ☐ Continued Therapy

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
DUPIXENT® *(dupilumab)*	☐ PFS ☐ Vial ☐ 300 mg/ 2 mL ☐ 200 mg/ 1.14 mL	☐ Inject 200 mg SUBQ every other week ☐ Inject 300 mg SUBQ every other week ☐ Inject 300 mg SUBQ every week		
EPIPEN® *(epinephrine injection)*	PFS 0.3 mg	☐ Inject intramuscularly or SUBQ into the anterolateral aspect of the thigh, through clothing if necessary.		
Pulmozyme® *(dornase alfa)*	2.5mg/mL ampules	☐ Once daily ☐ Twice daily		
Tezspire® *(tezepelumab-ekko)*	☐ PFS ☐ Vial 210 mg	☐ Inject 210mg SUBQ once every 4 weeks		
Tobi® single-dose ampoule *(tobramycin inhalation solution)*	300 mg/ 5 mL solution	☐ Inhale 300 mg twice daily for 28 days on and 28 days off		
Tobi Podhaler® capsule *(cyclosporine)*	28 mg per capsules	☐ Inhale the contents of 4 capsules via podhaler twice daily for 28 days		
Xolair *(omalizumab)*	☐ PFS ☐ Vial ☐ 75 mg ☐ 150 mg *Supplies dispensed: One 10mL vial sterile water for injection for every vial of Xolair dispensed, alcohol swabs, 3mL Luer Lock injection syringe, NDL 18G x 1 1/2" Safety Glide needle for reconstitution, NDL 25G x 5/8" Safety Glide needle for subcutaneous injectgion.* ☐ No supplies requested (supplies will be sent with shipment unless indicated)	☐ Inject 75mg SUBQ once every 4 weeks ☐ Inject 150mg SUBQ once every 4 weeks ☐ Inject 225mg SUBQ once every 2 weeks ☐ Inject 225mg SUBQ once every 4 weeks ☐ Inject 300mg SUBQ once every 2 weeks ☐ Inject 300mg SUBQ once every 4 weeks ☐ Inject 375mg SUBQ once every 2 weeks	28 Day Supply	
☐ **Other**				
☐ **Other**				
☐ **Other**				

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:	
Office Contact:	Email:		
Address:	City:	State:	ZIP:
NPI #:	Tax ID#:	Ship To: ☐ Patient ☐ MD Office	
Prescriber Signature:	Date:		