BioPlus® Specialty Pharmacy
A Carelon Company

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# Pulmonary (A-M)

**Phone:** 888-292-0744 **Fax:** 800-269-5493 **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 |
| 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<br>Last Injection Date: _____ / _____ / _____ |
| Drug Allergies | Weight ☐ kg ☐ lbs Height ☐ ft ☐ in |

## Prescription Information

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



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

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# Pulmonary (N-Z)

**Phone:** 888-292-0744 **Fax:** 800-269-5493 **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 |
| 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<br>Last Injection Date: _____ / _____ / _____ |
| Drug Allergies | Weight ☐ kg ☐ lbs Height ☐ ft ☐ in |

## Prescription Information

| | | | Qty | Refills |
|---|---|---|---|---|
| ☐ Nintedanib Esylate | ☐ 100mg Capsule<br>☐ 150mg Capsule | ☐ Take 1 capsule PO twice daily with food, approximately 12 hours apart | _____ | _____ |
| ☐ Nucala® *(mepolizumab)* | ☐ 100mg Vial<br>☐ 100mg/mL PFS<br>☐ 100mg/mL Pen<br><br>☐ Sterile Water for Injection 10mL Vial | **Asthma/COPD (Chronic Bronchitis or Emphysema):**<br>☐ Inject 100mg SUBQ once every 4 weeks<br>**Eosinophilic Granulomatosis with Polyangiitis (EGPA):**<br>☐ Inject 300mg (3 x 100mg) SUBQ once every 4 weeks | 1<br><br>3<br>QS | _____<br><br>_____<br>_____ |
| ☐ Macitentan | ☐ 10mg Tablet | ☐ Take 1 tablet PO once daily | _____ | _____ |
| ☐ Pulmozyme® *(dornase alfa)* | ☐ 2.5mg/2.5mL Ampule | ☐ Inhale 1 ampule via nebulizer once daily<br>☐ Inhale 1 ampule via nebulizer twice daily | 30<br>60 | _____<br>_____ |
| ☐ Tezspire® *(tezepelumab-ekko)* | ☐ 210mg/1.91mL PFS<br>☐ 210mg/1.91mL Pen | ☐ Inject 210mg SUBQ once every 4 weeks | 1 | _____ |
| ☐ Tobramycin Inhalation Solution | ☐ 300mg/4mL Ampule<br>☐ 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<br>☐ 75mg/0.5mL PFS<br>☐ 75mg/0.5mL Pen<br>☐ 150mg/mL PFS<br>☐ 150mg/mL Pen<br>☐ 300mg/2mL PFS<br>☐ 300mg/2mL Pen<br>☐ Sterile Water for Injection 10mL Vial | ☐ Inject 225mg SUBQ once every 2 weeks<br>☐ Inject 300mg SUBQ once every 2 weeks<br>☐ Inject 375mg SUBQ once every 2 weeks<br>☐ Inject 150mg SUBQ once every 4 weeks<br>☐ Inject 300mg SUBQ once every 4 weeks | 28 Day Supply<br><br><br><br><br><br><br>QS | _____<br><br><br><br><br><br><br>_____ |
| ☐ Other | | | | |



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