

Allergy/Immunology Referral Form

Fax completed form to: 833-908-1122



PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:	Lic.#:	DEA #:	
Practice Name:		NPI#:	
Address:		City/State/Zip:	
Office Contact:	Phone:	Fax:	
Supervisory Physician (if applicable):			
PLEASE ATTACH			
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates)		IGE levels (XOLAIR only) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line			
Lab Orders:			
Lab Date & Frequency:			
PRESCRIPTION ORDERS			
Anaphylaxis Kit: (Check all that apply)	Epinephrine 0.3mg IM as needed Diphenhydramine _____ mg IV as needed	Solu-cortef 250mg-500mg IV as needed NS Hydration 500 ml IV over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV as needed Other _____
Pre-Medications: (Check all that apply)	Acetaminophen _____ mg PO _____ minutes prior to infusion Diphenhydramine _____ mg PO ---OR--- IV _____ minutes prior to infusion	Solu-Medrol _____ mg IV _____ minutes prior to infusion	Other _____
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose?	Yes	No	If No, when was last dose given? _____ When is patient due for next dose? _____
CINQAIR	3mg/kg IV infusion via gravity ---OR--- pump once every 4 weeks over 20-50 minutes		_____
FASENRA	Induction: 30mg SubQ injection every 4 weeks for the first 3 doses		NONE
	Maintenance: 30mg SubQ injection once every 8 weeks		_____
NUCALA	100mg SubQ injection every 4 weeks		_____
	300mg SubQ injection every 4 weeks		_____
XOLAIR	_____ mg SubQ injection every _____ weeks		_____
IG	For Immunoglobulin therapy please refer to IG Order Form		_____
OTHER	_____		_____
By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.			

Prescriber's Signature _____
Dispense as Written

Print Name _____
Date _____

Prescriber's Signature _____
Substitution Permitted

Print Name _____
Date _____

