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:	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV as needed	Solu-Medrol 60mg - 125mg IV as needed
(Check all that apply)	Diphenhydramine ________ mg IV as needed	NS Hydration 500 ml IV over 30 minutes as needed	Other
Pre-Medications:	Acetaminophen ________mg PO ________ minutes prior to infusion	Solu-Medrol ______mg IV ___minutes prior to infusion	
(Check all that apply)	Diphenhydramine ________ mg PO ***---OR---*** 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 **<u>Dispense as Written</u>**	**Print Name**	**Date**
Prescriber's Signature **<u>Substitution Permitted</u>**	**Print Name**	**Date**

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AME NEX Allergy Refer 10-23

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