Allergy/Immunology Referral Form

Fax Completed Form To: **Phone:**

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 **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

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