

Pulmonary 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) Documentation on phenotype (Aralast and Glassia only) Chest x-ray results (Aralast and Glassia only) CT scan results (Aralast and Glassia only) IgA level (Aralast and Glassia only)	Eosinophil levels (Fasenra, Cinqair and Nucala only) Alpha-1 antitrypsin levels (Aralast and Glassia only) FEV1 score (Aralast and Glassia only) Current Smoker? Yes No (Aralast and Glassia only) Line access documentation/verification if applicable 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 infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	Diphenhydramine _____ mg IV infusion as needed	NS Hydration 500 ml IV infusion 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 infusion _____ 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? _____	
ARALAST	60mg/kg IV infusion via gravity ---OR--- pump weekly over approximately 15 minutes *Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch	_____
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	_____
GLASSIA	60mg/kg IV infusion via gravity ---OR--- pump once weekly over approximately 15 minutes *Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch	_____
NUCALA	100mg SubQ injection every 4 weeks 300mg SubQ injection every 4 weeks	_____
TEZSPIRE	210mg SubQ injection once every 4 weeks	_____
XOLAIR	_____ mg SubQ injection every _____ weeks	_____
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
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