

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:	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 _____
 Dispense as Written _____
 Print Name _____
 Date _____

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