

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:	<input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical)	<input type="checkbox"/> Eosinophil levels (<i>Fasenra, Cinqair and Nucala only</i>)
<input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results	<input type="checkbox"/> Alpha-1 antitrypsin levels (<i>Aralast and Glassia only</i>)
<input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates)	<input type="checkbox"/> FEV1 score (<i>Aralast and Glassia only</i>)
<input type="checkbox"/> Documentation on phenotype (<i>Aralast and Glassia only</i>)	<input type="checkbox"/> Current Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Aralast and Glassia only</i>)
<input type="checkbox"/> Chest x-ray results (<i>Aralast and Glassia only</i>)	<input type="checkbox"/> Line access documentation/verification if applicable
<input type="checkbox"/> CT scan results (<i>Aralast and Glassia only</i>)	<input type="checkbox"/> Letter of medical necessity if drug dosing or indication is outside of FDA guidelines
<input type="checkbox"/> IgA level (<i>Aralast and Glassia only</i>)	

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 - <input type="checkbox"/> 10units/mL ---OR--- <input type="checkbox"/> 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line
Lab Orders: Lab Date & Frequency:

PRESCRIPTION ORDERS	
Anaphylaxis Kit: <input type="checkbox"/> Epinephrine 0.3mg IM as needed <input type="checkbox"/> Solu-cortef 250mg-500mg IV infusion as needed <input type="checkbox"/> Solu-Medrol 60mg - 125mg IV infusion as needed	
(Check all that apply) <input type="checkbox"/> Diphenhydramine _____mg IV infusion as needed <input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed <input type="checkbox"/> Other	
Pre-Medications: <input type="checkbox"/> Acetaminophen _____mg PO _____minutes prior to infusion <input type="checkbox"/> Solu-Medrol _____mg IV _____minutes prior to infusion	
(Check all that apply) <input type="checkbox"/> Diphenhydramine _____mg <input type="checkbox"/> PO ---OR--- <input type="checkbox"/> IV infusion _____minutes prior to infusion <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was last dose given? _____ When is patient due for next dose? _____		
<input type="checkbox"/> ARALAST	60mg/kg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump weekly over approximately 15 minutes <i>*Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch</i>	_____
<input type="checkbox"/> CINQAIR	3mg/kg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump once every 4 weeks over 20-50 minutes	_____
<input type="checkbox"/> FASENRA	<input type="checkbox"/> Induction: 30mg SubQ injection every 4 weeks for the first 3 doses	NONE
	<input type="checkbox"/> Maintenance: 30mg SubQ injection once every 8 weeks	_____
<input type="checkbox"/> GLASSIA	60mg/kg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump once weekly over approximately 15 minutes <i>*Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch</i>	_____
<input type="checkbox"/> NUCALA	<input type="checkbox"/> 100mg SubQ injection every 4 weeks <input type="checkbox"/> 300mg SubQ injection every 4 weeks	_____
<input type="checkbox"/> TEZSPIRE	210mg SubQ injection once every 4 weeks	_____
<input type="checkbox"/> XOLAIR	_____mg SubQ injection every _____weeks	_____
<input type="checkbox"/> 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	Prescriber's Signature	Print Name	Date
<u>Dispense as Written</u>			<u>Substitution Permitted</u>		