Pulmonary Referral Form

Fax Completed Form To: 877-418-4495   Phone: 877-418-4114

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: (Check all that apply)
Epinephrine 0.3mg IM as needed   Solu-cortef 250mg-500mg IV infusion as needed   Solu-Medrol 60mg - 125mg IV infusion as needed
Diphenhydramine ________ mg IV infusion as needed   NS Hydration 500 ml IV infusion over 30 minutes as needed   Other

Pre-Medications: (Check all that apply)
Acetaminophen ________mg PO ________ minutes prior to infusion   Solu-Medrol ______mg IV ____minutes prior to infusion
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 **Print Name** **Date**
Dispense as Written

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

ACHC ACCREDITED

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