Pulmonary Referral Form

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

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specialty infusion services

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

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