

# Pulmonary Referral Form

Fax Completed Form To: 844-815-2606



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 ( <i>Aralast and Glassia only</i> ) Chest x-ray results ( <i>Aralast and Glassia only</i> ) CT scan results ( <i>Aralast and Glassia only</i> ) IgA level ( <i>Aralast and Glassia only</i> )		Eosinophil levels ( <i>Fasenra, Cinqair and Nucala only</i> ) Alpha-1 antitrypsin levels ( <i>Aralast and Glassia only</i> ) FEV1 score ( <i>Aralast and Glassia only</i> ) Current Smoker?    Yes    No ( <i>Aralast and Glassia only</i> ) Line access documentation/verification if applicable Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> 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 <b>Lab Orders:</b>			
<b>Lab Date &amp; Frequency:</b>			
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b>	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 _____
<b>Pre-Medications:</b>	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 _____	
<b>Supply Orders:</b> 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	<b>Induction:</b> 30mg SubQ injection every 4 weeks for the first 3 doses	<b>Maintenance:</b> 30mg SubQ injection once every 8 weeks	NONE
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			_____
<b>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.</b>			

Prescriber's Signature Dispense as Written	Print Name	Date	Prescriber's Signature Substitution Permitted	Print Name	Date
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