

Pulmonary Referral Form

Fax Completed Form To:

Phone:

Amerita
YOUR INFUSION ADVOCATE

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		Referral Date:	
Home Phone:		City/State/Zip:	
Cell Phone:		Work Phone:	
Secondary Contact:		Height: Weight: ☐ Male ☐ Female	
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
Office Contact:		City/State/Zip:	
Phone:		Fax:	
Supervisory Physician (if applicable):			
PLEASE ATTACH			
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)		☐ Eosinophil levels (<i>Fasenra, Cinqair and Nucala only</i>)	
☐ Recent office visit notes, history & physical, lab & pertinent procedure results		☐ Alpha-1 antitrypsin levels (<i>Aralast and Glassia only</i>)	
☐ Current medication list & list of prior medications tried and failed (with dates)		☐ FEV1 score (<i>Aralast and Glassia only</i>)	
☐ Documentation on phenotype (<i>Aralast and Glassia only</i>)		☐ Current Smoker? ☐ Yes ☐ No (<i>Aralast and Glassia only</i>)	
☐ Chest x-ray results (<i>Aralast and Glassia only</i>)		☐ Line access documentation/verification if applicable	
☐ CT scan results (<i>Aralast and Glassia only</i>)		☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
☐ 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 - ☐ 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 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			
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 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 <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>		_____
☐ 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 ☐ Maintenance: 30mg SubQ injection once every 8 weeks		NONE
☐ GLASSIA	60mg/kg IV infusion via ☐ gravity ---OR--- ☐ 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>		_____
☐ 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 to assist with prior authorization requests acting as your pharmacy provider 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