

Allergy/Immunology Referral Form

Fax Completed Form To:

Phone:

Amerita
YOUR INFUSION ADVOCATE

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		City/State/Zip:	
Home Phone:		Cell Phone:	
Secondary Contact:		Work Phone:	
Patient Diagnosis & ICD-10:		☐ Male ☐ Female	
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) ☐ Recent office visit notes, history & physical, lab & pertinent procedure results ☐ Current medication list & list of prior medications tried and failed (with dates)		☐ IGE levels (XOLAIR only) ☐ 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: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed (Check all that apply) ☐ Diphenhydramine _____mg IV as needed ☐ NS Hydration 500 ml IV 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 _____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? _____			
☐ 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		_____
	☐ New Indication: Eosinophilic Granulomatosis with Polyangiitis 30mg q4 weeks		_____
☐ NUCALA	☐ 100mg SubQ injection every 4 weeks ☐ 300mg SubQ injection every 4 weeks		_____
☐ XOLAIR	_____mg SubQ injection every _____weeks		_____
☐ IG	For Immunoglobulin therapy please refer to IG Order Form		_____
☐ Dupixent			_____
☐ Tezspire			_____
☐ Garadacimab			_____
☐ OTHER			_____
<i>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.</i>			

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date



ACHC
ACCREDITED

