

REFERRAL STATUS

- NEW REFERRAL
 DOSE/FREQUENCY CHANGE
 ORDER RENEWAL

PATIENT INFORMATION

NAME: _____
 DATE OF BIRTH: ____/____/____
 PHONE: (____) _____-_____
 ALLERGIES: _____

 WEIGHT: _____ LBS HEIGHT: _____ IN

PLEASE ATTACH DEMOGRAPHICS, CLINICALS, AND LABS

PROVIDER INFORMATION

NAME: _____
 NPI: _____
 SIGNATURE: _____
 PHONE: (____) _____-_____
 FAX: (____) _____-_____
 CONTACT PERSON: _____
 DATE: ____/____/____ REFILLS: _____

ALL ORDERS ARE VALID FOR ONE YEAR, UNLESS SPECIFIED

MEDICAL INFORMATION (REQUIRED)

- FASENRA/NUCALA (FOR ASTHMA OR HES)/CINQAIR: CBC WITH D/P
 XOLAIR: POSITIVE RAST TEST (FOR ASTHMA), IgE SERUM
 TEZSPIRE: FEV LEVEL
 IVIG: CBC, CMP, OR BMP; IG SERUM (OPTIONAL)

MEDICATION ORDERS

- XOLAIR 150MG SQ EVERY _____ WEEKS
 XOLAIR 225MG SQ EVERY _____ WEEKS
 XOLAIR 300MG SQ EVERY _____ WEEKS
 XOLAIR 375MG SQ EVERY _____ WEEKS
 XOLAIR _____ MG SQ EVERY _____ WEEKS

 CINQAIR 3MG/KG IV EVERY 4 WEEKS

 FASENRA 30MG SQ AT WEEKS 0, 4, 8 AND EVERY 8 WEEKS THERE AFTER
 FASENRA 30MG SQ EVERY 8 WEEKS

 NUCALA 100MG SQ EVERY 4 WEEKS
 NUCALA 300MG SQ EVERY 4 WEEKS

 DUPIXENT 600MG SQ AT WEEK 0, 300MG AT WEEK 2
 DUPIXENT 300MG SQ EVERY OTHER WEEK

 TEZSPIRE 210MG SQ EVERY 4 WEEKS

IVIG:

- | | | |
|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> GAMUNEX-C | <input type="checkbox"/> BIVIGAM | <input type="checkbox"/> FLEBOGAMMA 10% |
| <input type="checkbox"/> GAMMAGARD | <input type="checkbox"/> CYTOGAM | <input type="checkbox"/> CARIMUNE _____ % |
| <input type="checkbox"/> PANZYGA | <input type="checkbox"/> OCTAGAM | <input type="checkbox"/> GAMMAKED |
| <input type="checkbox"/> FLEBOGAMMA | <input type="checkbox"/> GAMMAPLEX | <input type="checkbox"/> PRIVIGEN |

DOSAGE: _____ GM IV DIVIDED OVER _____ DAY(S)
 FREQUENCY: EVERY _____ WEEKS

DIAGNOSIS

- J45.50 SEVERE PERS ASTHMA, UNCOMP
 L50.0 CHRONIC IDIOPATHIC URTICARIA
 J45.51 SEVERE PERS ASTHMA W/ ACUTE EXACERBATION
 M30.1 POLYARTERITIS W/ LUNG INVOLV
 COMMON VARIABLE IMMUNODEFICIENCY

ICD-10: _____

OTHER: _____

ICD-10: _____

PRE-MEDICATIONS

BENADRYL IV _____ MG
 REGLAN IV _____ MG
 SOLUMEDROL IV _____ MG
 ZOFRAN IV _____ MG
 OTHER IV _____ MG

BENADRYL PO _____ MG
 TYLENOL PO _____ MG
 ZYRTEC PO _____ MG
 ZOFRAN PO _____ MG
 ZANTAC PO _____ MG
 OTHER PO _____ MG