

ALLERGY/IMMUNOLOGY

New Prescription/Referral
Prescription Refill

Of Refills: _____

Rx:

Patient Name: _____

Patient Weight: _____

kg

DOB: _____

Persistent Asthma
(ICD-10 Code: _____)
Chronic Idiopathic Urticaria
(ICD-10 Code: _____)
Nasal Polyps
(ICD-10 Code: _____)

Xolair	75mg Sub-Q	150mg Sub-Q	225mg Sub-Q	300mg Sub-Q
	375mg Sub-Q	450mg Sub-Q	525mg Sub-Q	600mg Sub-Q
Xolair Frequency:	Every 2 weeks	Every 4 weeks		

Severe Asthma with
Eosinophilic Phenotype
(ICD-10 Code: _____)

Severe Granulomatosis
with Polyangiitis
(ICD-10 Code: _____)

Cinqair 3mg/kg IV every 4 weeks
Fasenra Initial Dose: 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30mg Sub-Q every 8 weeks thereafter
Fasenra 30mg Sub-Q every 8 weeks
Nucala 100mg Sub-Q every 4 weeks
Nucala 300mg Sub-Q every 4 weeks
Tezspire 210mg Sub-Q every 4 weeks

Common Variable
Immunodeficiency
(ICD-10 Code: _____)

Other: _____

(ICD-10 Code: _____)

IVIG: Gamunex (10%) Privigen (10%) Octagam (10%) Gammaplex (10%)
Gammagard (10%) Bivigam (10%) Gammaked (10%) Flebogamma DIF (10%)
Asceniv (10%) Panzyga (10%) Other Orders: _____
Dosage: _____g/day IV _____g/kg IV Over _____# of days _____# of months
Frequency: One-Time Only every _____weeks (Optional: Start Date _____)

Pre-Medications:

Solumedrol 125mg IVP
Solu-Cortef 100mg IVP
Other: _____

Tylenol _____mg PO
650 mg 975 mg

Benadryl _____mg PO
25 mg IV
50 mg PO

ANA Kit Protocol

OK to use

Physician Signature

NPI #:

DATE:(Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: _____

Clinic: _____

Phone: _____

Fax: _____

Email: _____

Other: _____

Office Mailing Address: _____

Please include the following

*Patient demographics
*Lab Results

*Insurance attached
*Clinical progress notes

*Diagnosis(supporting)
*Medication list

*History & Physical
*Other Test Results

Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcl within the past 6 weeks (asthma & EGPA) or ≥ 1000 cells/mcl within 4 weeks (HES)? Yes No

FEV1 score (if applicable): _____

Serum IgE level - **for asthma & nasal polyps Xolair**

Serum Immunoglobulins - **for IVIG**

Skin/RAST test - **for asthma Xolair**

Serum Creatinine - **for IVIG**

CBC w/differential - **for Fasenra, Nucala, Cinqair**

If injection order, is the patient or caregiver not competent or physically unable to administer the product for self-administration?
Yes No

Xolair - Patient has Epi pen prescribed

Other medical necessity: _____