ALLERGY/IMMUNOLOGY

***Patient Insurance & ID (front and back) are needed**

☐ 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 ☐ *Insurance attached ☐ *Diagnosis(supporting) ☐ *History & Physical
☐ *Lab Results ☐ *Clinical progress notes ☐ *Medication list ☐ *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**
☐ Skin/RAST test - **for asthma Xolair**
☐ CBC w/differential - **for Fasenra, Nucala, Cinqair**
☐ Serum Immunoglobulins - **for IVIG**
☐ Serum Creatinine - **for IVIG**

☐ 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:_____

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.