FAX: 725.228.5220

eMediate INFUSION

ALLERGY/IMMUNOLOGY

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

Name: | DOB: | Weight: kg

PHYSICIAN INFORMATION

Prescriber Name: | Phone: | Fax:

Office Contact: | *Email (for the referral update):

Clinic: | Address:

NPI:

Patient's PCP Name: | Phone: | Fax:

Clinic: | Address:

NPI:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Xolair (omalizumab)	☐ 75mg Sub-Q ☐ 150mg Sub-Q ☐ 225mg Sub-Q ☐ 300mg Sub-Q ☐ 375mg Sub-Q ☐ 450mg Sub-Q ☐ 525mg Sub-Q ☐ 600mg Sub-Q ☐ Every 2 weeks ☐ Every 4 weeks
Cinqair (reslizumab)	☐ 3mg/kg IV every 4 weeks
Fasenra (benralizumab)	☐ 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30mg Sub-Q every 8 weeks thereafter ☐ 30mg Sub-Q every 4 weeks ☐ 30mg Sub-Q every 8 weeks
Nucala (mepolizumab)	☐ 100mg Sub-Q every 4 weeks ☐ 300mg Sub-Q every 4 weeks
Tezspire (tezepelumab)	☐ 210mg Sub-Q every 4 weeks
IVIG: ☐ OK to use biosimilar	☐ 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 ☐ _____g/kg ☐ 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

Dx:

Diagnosis_____

ICD-10: _____

PRESCRIBER SIGNATURE: x | Date (Valid for 1 year):

I authorize eMediate Infusion Center, PLLC , Assist Point Clinical or its authorized representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to eMediate Infusion Center.

ALLERGY/IMMUNOLOGY

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PATIENT INFORMATION

Name:	DOB:

REQUIRED INFORMATION (please attach)

☐ **Patient demographics** ☐ **Insurance attached** ☐ **Diagnosis(supporting)** ☐ **History & Physical**

☐ **Lab Results (attach results)** ☐ **Clinical progress notes** ☐ **Medication list** ☐ **Other Test Results**

☐ Asthma - Does the patient have a history of 2 exacerbations requiring a course of oral/ systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? ☐ Yes ☐ No

☐ Asthma - Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? ☐ Yes ☐ No

☐ PI - Documentation of recurrent bacterial infections, history of failure to respond to antibiotics, documentation of pre and post pneumococcal vaccine titers

☐ 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:_____