

Allergy/Immunology Referral Form

Fax Completed Form To:

Phone:



PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:	City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:		
Allergies:		
PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:	NPI#:	
Address:	City/State/Zip:	
Office Contact:	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: (Check all that apply)	☐ Epinephrine 0.3mg IM as needed ☐ Diphenhydramine _____mg IV as needed	☐ Solu-cortef 250mg-500mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Solu-Medrol 60mg - 125mg IV as needed ☐ Other
Pre-Medications: (Check all that apply)	☐ Acetaminophen _____mg PO _____minutes prior to infusion ☐ Diphenhydramine _____mg ☐ PO ---OR--- ☐ IV _____minutes prior to infusion	☐ Solu-Medrol _____mg 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	_____
☐ 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	_____
☐ OTHER		_____
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.		

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date



ACHC
ACCREDITED

