# Pulmonary Referral Form

amerita specialty infusion services

InfusionRx an amerita company

**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)
- ☐ Documentation on phenotype *(Aralast and Glassia only)*
- ☐ Chest x-ray results *(Aralast and Glassia only)*
- ☐ CT scan results *(Aralast and Glassia only)*
- ☐ IgA level *(Aralast and Glassia only)*
- ☐ Eosinophil levels *(Fasenra, Cinqair and Nucala only)*
- ☐ Alpha-1 antitrypsin levels *(Aralast and Glassia only)*
- ☐ FEV1 score *(Aralast and Glassia only)*
- ☐ Current Smoker? ☐ Yes ☐ No *(Aralast and Glassia only)*
- ☐ Line access documentation/verification if applicable
- ☐ 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 ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

**Pre-Medications:** (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV ____minutes prior to infusion
☐ Diphenhydramine _____mg ☐ PO ***---OR---*** ☐ IV infusion _____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?_____ | | |
| ☐ ARALAST | 60mg/kg IV infusion via ☐ gravity ***---OR---*** ☐ pump weekly over approximately 15 minutes<br>**Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch* | _____ |
| ☐ 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 | _____ |
| ☐ GLASSIA | 60mg/kg IV infusion via ☐ gravity ***---OR---*** ☐ pump once weekly over approximately 15 minutes<br>**Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch* | _____ |
| ☐ NUCALA | ☐ 100mg SubQ injection every 4 weeks ☐ 300mg SubQ injection every 4 weeks | _____ |
| ☐ TEZSPIRE | 210mg SubQ injection once every 4 weeks | _____ |
| ☐ XOLAIR | _____mg SubQ injection every _____weeks | _____ |
| ☐ 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** **Print Name** **Date**
**Dispense as Written**

**Prescriber's Signature** **Print Name** **Date**
**Substitution Permitted**


*AME IRX_PULMONARY REFER 6.25*

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**THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.**

URAC ACCREDITED Specialty Pharmacy 08/01/2020 ACHC ACCREDITED PCAB ACCREDITED Compounding Pharmacy