InfuCare Rx

Asthma/Allergy Referral Form

of Pages Faxed:__________
Fax Referral To: 844-504-3278
Phone: 877-327-8881

Date Required:__________ Ship To: ☐ Patient ☐ MD Office ☐ Other:__________

PATIENT INFORMATION

Patient Name:__________
Address:__________
City, State, Zip:__________
Home Phone:__________
Cell Phone:__________
Date of Birth:__________ ☐ Male ☐ Female
Emergency Contact:__________ Phone:__________

PRESCRIBER INFORMATION

Prescriber Name:__________
Address:__________
City, State, Zip:__________
Phone:__________
Fax:__________
DEA #:__________ NPI #:__________
Contact Person:__________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance:__________ ID:__________ Group:__________
Secondary Insurance:__________ ID:__________ Group:__________
Prescription Card:__________ ID:__________ BIN:__________ PCN:__________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ J45.909 Asthma, Unspecified
☐ L20.9 Atopic Dermatitis
☐ L50.1 Chronic Idiopathic Urticaria
☐ J45.40 Moderate Persistent Asthma, uncomplicated
☐ J45.41 Moderate Persistent Asthma w/ acute exacerbation
☐ J33.0 Polyp of Nasal Cavity
☐ D86.9 Sarcoidosis, unspecified
☐ Other:__________

Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in %BSA:_____
Allergies:__________ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other:__________
Eosinophil count _____ cells/uL IgE Levels _____ Date of Test _____
Number of exacerbations in the last 12 months _____
☐ Patient is not a candidate for surgery Rationale:__________

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills
Dupixent® (dupilumab)	☐ 200 mg/1.14 mL prefilled syringe 2 pack	☐ **Starter Dose:** Administer two syringes (total of 400 mg) subcutaneously on Day 1 then one syringe (200 mg) every two weeks starting on Day 15 thereafter ☐ **Maintenance Dose:** Administer 200mg subcutaneously every two weeks	☐ 2	
	☐ 300 mg/2 mL prefilled syringe 2 pack	☐ **Starter Dose:** Administer two syringes (total of 600 mg) subcutaneously on Day 1 then one syringe (300 mg) every two weeks starting on Day 15 therea fter ☐ **Maintenance Dose:** Administer 300mg subcutaneously every two weeks ☐ Inject 300 mg subcutaneously every other week **Dosing intended for chronic rhinosinusitis with nasal polyposis (CRSwNP)**	☐ 2	
Fasenra™ (benralizumab)	☐ 30mg PFS ☐ 30mg Autoinjector	☐ **Starter Dose:** Administer 30mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter ☐ **Maintenance Dose:** Administer 30mg subcutaneously every 8 weeks		
Nucala® (mepolizumab)	☐ 100mg vial ☐ 100mg PFS ☐ 100mg Autoinjector	☐ Inject 100mg subcutaneously once every 4 weeks into the upper arm, thigh, or ☐ abdomen **Supplies:** • 1 sterile water for injection (10ml) for every vial of Nucala dispensed • 1-ml polyprophylene syringe with 21-to 27-G x 0.5-inch needle for subcutaneous injection • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution Send quantity sufficient for medication days supply. ☐ No supplies (The above supplies will be sent with shipment unless indicated).	☐ 28 days	
Xolair® (Omalizumab) ☐ Asthma ☐ CIU	☐ 75mg PFS ☐ 150mg PFS ☐ 150 mg single dose vial	Every 4 week dosing: ☐ Administer 75 mg dose subcutaneously every 4 weeks ☐ Administer 150 mg dose subcutaneously every 4 weeks ☐ Administer 300 mg dose subcutaneously every 4 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 4 weeks Every 2 week dosing: ☐ Administer 75 mg dose subcutaneously every 2 weeks ☐ Administer 150 mg dose subcutaneously every 2 weeks ☐ Administer 300 mg dose subcutaneously every 2 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 2 weeks ☐ **Supplies:** • 1 vial sterile water for injection (10 mL vial) for every vial of Xolair dispensed • NDL 25G x 5/8" Safety Glide needle for subcutaneous injection • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL Luer Lock injection syringe • NDL 18G x 1 & ½" Safety Glide needle for reconstitution Send quantity sufficient for medication days supply. ☐ No supplies (The above supplies will be sent with shipment unless indicated).		

Prescriber Signature:__________ **Date:**__________

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