Pulmonary Infusion

Referral Form

Email: intake@infuseoneohio.com
Fax: (614) 929-7199

INFUSE ONE OHIO

PLEASE ATTACH INSURANCE CARDS - FRONT AND BACK

☐ Dublin, OH ☐ Lancaster, OH

PATIENT INFORMATION

Last Name, First Name | **Date of Birth** | **Gender** ☐ M ☐ F

Address | **City, State, ZIP** | **Phone**

REFERRING PROVIDER INFORMATION

Referring Practice | **Practice Address / City / State / ZIP**

Prescriber Name | **Prescriber NPI** | **Nurse / Key Contact** | **Phone**

Fax | **Email**

DIAGNOSIS & CLINICAL INFORMATION

ICD-10 | **Description**

☑ Use Infuse One Ohio hypersensitivity protocol

PRESCRIPTION ORDERS

ANAPHYLAXIS KIT (Check all that apply)

☐ Epinephrine 0.3 mg IM as needed ☐ Solu-Cortef 250-500 mg IV infusion as needed ☐ Solu-Medrol 60-125 mg 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

PRESCRIPTION INFORMATION

Is this a first dose? ☐ Yes ☐ No | **If no, when was last dose given?** | **When is patient due for next dose?**

		Refills
☐ Aralast	60 mg/kg IV weekly over ~15 min; rate <=0.2 mL/kg/min; vial allotment +/-10%.	
☐ Cinqair	3 mg/kg IV every 4 weeks over 20-50 minutes.	
☐ Fasenra	☐ Induction: 30mg SubQ every 4 weeks for the first 3 doses ☐ Maintenance: 30 mg every 8 weeks.	NONE
☐ Glassia	60 mg/kg IV over ~15 min; rate <=0.2 mL/kg/min; vial allotment +/-10%.	
☐ Nucala	☐ 100 mg SubQ every 4 weeks ☐ 300 mg SubQ every 4 weeks	
☐ Tezspire	210 mg SubQ every 4 weeks.	
☐ Xolair	_____ mg SubQ every _____ weeks.	
☐ Exdensur	☐ 100 mg SubQ once every 6 months	
☐ Other		

By signing, you authorize Infuse One Ohio to serve as your prior authorization designated agent with medical and prescription insurers.

DISPENSE AS WRITTEN — **Prescriber's Signature** | **Print Name** | **Date**

SUBSTITUTION PERMITTED — **Prescriber's Signature** | **Print Name** | **Date**

PLEASE ATTACH THE FOLLOWING

- ☐ Patient demographics and all insurance cards (front/back) (prescription and medical)
- ☐ Recent office notes, H&P, labs, and pertinent results
- ☐ Current medications and prior medications tried/failed (dates)
- ☐ Phenotype documentation (Aralast/Glassia only)
- ☐ Chest x-ray results (Aralast/Glassia only)
- ☐ CT scan results (Aralast/Glassia only)
- ☐ IgA level (Aralast/Glassia only)
- ☐ Eosinophil levels (Fasenra/Cinqair/Nucala only)
- ☐ Alpha-1 antitrypsin levels (Aralast/Glassia only)
- ☐ FEV1 score (Aralast/Glassia only)
- ☐ Current smoker? ☐ Yes ☐ No (Aralast/Glassia only)
- ☐ Line access documentation, if applicable
- ☐ Medical necessity letter for non-FDA dosing/indication