

Pulmonary Infusion

Referral Form

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



PLEASE ATTACH INSURANCE CARDS - FRONT AND BACK

Dublin, OH Lancaster, OH

PATIENT INFORMATION

Last Name, First Name	Date of Birth	Gender	M	F	Other
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.		
Exdusur			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)	Eosinophil levels (Fasenra/Cinqair/Nucala only)
Recent office notes, H&P, labs, and pertinent results	Alpha-1 antitrypsin levels (Aralast/Glassia only)
Current medications and prior medications tried/failed (dates)	FEV1 score (Aralast/Glassia only)
Phenotype documentation (Aralast/Glassia only)	Current smoker? Yes No (Aralast/Glassia only)
Chest x-ray results (Aralast/Glassia only)	Line access documentation, if applicable
CT scan results (Aralast/Glassia only)	Medical necessity letter for non-FDA dosing/indication
IgA level (Aralast/Glassia only)	