

# Allergy/Immunology Order Form

Fax completed form to: \_\_\_\_\_



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
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.
<b>Flush Orders:</b> 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
<b>Lab Orders:</b>
<b>Lab Date &amp; Frequency:</b>

PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> (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
<b>Pre-Medications:</b> (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
<b>Supply Orders:</b> 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	<b>Induction:</b> 30mg SubQ injection every 4 weeks for the first 3 doses	NONE
	<b>Maintenance:</b> 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	<b>For Immunoglobulin therapy please refer to IG Order Form</b>	_____
OTHER		_____

*By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent 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 \_\_\_\_\_

