ALLERGY IMMUNO

REFERRAL FORM

DELIVERIT™
Infusion & Specialty

Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Face Sheet from Patient Chart)

Primary Insurance		Name of the Insured		Relationship	
Member ID#		Group #		Insurance Phone #	
Secondary Rx Carrier		Rx ID #		Rx Group #	

COMPLETE PATIENT MEDICAL INFORMATION IN THE SECTION BELOW

Diagnosis Date:		ICD-10:		Relationship	

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached	Insurance Phone #:	
History of Allergic Asthma (Xolair): Positive Skin or RAST Test ☐ Yes ☐ No	Test Date:	

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Required labs: ☐ CBC with differential (Cinqair, Fasenra and Nucala) ☐ BMP or Cr (IVIG)

Lab Orders:	

*Note: Patient must have their EpiPen in their possession at every Xolair appointment

Infusion Orders

Diagnosis	Infusion Orders	Refills
☐ Allergic Asthama ICD-10 __________ ☐ Diverticulitis ICD-10 __________	☐ **Xolair** 150mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for ____ months ☐ **Xolair** 225mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for ____ months ☐ **Xolair** 300mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for ____ months ☐ **Xolair** 375mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for ____ months	☐ ______ ☐ x 1year
☐ Severe Allergic Asthama with Eosinophilic phenotype ICD-10 __________ ☐ Eosinophilic Granulomatosis With Polyangiitis ICD-10 __________	☐ Cinqair 3mg/kg IV every 4 weeks for ____ months ☐ Fasenra initial dose: 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30mg Sub-Q every 8 weeks thereafter for ____ months ☐ **Fasenra** maintenance dose: 30mg Sub-Q every 8 weeks for ____ months ☐ **Nucala** 100mg Sub-Q every 4 weeks for ____ months ☐ **Nucala** 300mg Sub-Q every 4 weeks for ____ months	☐ ______ ☐ x 1year

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Infusion Orders

Diagnosis	Infusion Orders	Refills
☐ Common Variable Immunodeficiency ICD-10 ___________ ☐ Other ___________ ICD-10 ___________	**IVIG Brand:** ☐ Bivigam ☐ Gammagard ☐ Gammaplex ☐ Octagam ☐ Cytogam ☐ Gammamaked ☐ Gamunex C ☐ Privigen **IVIG Pre-medication Orders:** ☐ Tylenol 1000mg **Antihistamine:** ☐ Cetrizine 10mg PO ☐ Loratadine 10mg PO ☐ Diphenhydramine 25mg PO **Additional Pre-Medication Orders:** ☐ Solu-Medrol ___mg IVP ☐ NS 0.9% ____ml IV ☐ IVIG Order: ____mg/kg IV over ____ day(s) ☐ IVIG Order: ____gm/kg IV over ____ day(s) **Frequency:** ☐ Every ___ weeks for ___ months or ☐ One-time dose ONLY	☐ ______ ☐ x 1year
	Hypersensitivity/Anaphylaxis Response Protocol PRN	

Prescriber Insurance Information

Prescriber Name		**NPI#**		**Office #**		**Fax #**	
Address		**City**		**State**		**Zip Code**	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Date

☐ DAW (Dispense as written).

Prescriber's Signature

X ______________________________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

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