

# Asthma & Allergy

Referral for Medication and Patient Management Program



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**\*\*Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents\*\***

Patient Demographics	Provider Information
Name _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber _____
DOB _____ SSN _____	NPI _____ DEA _____
Phone _____ 2 <sup>nd</sup> Phone _____	Practice Name _____
Address _____ Apt/Suite _____	Address _____
City, State, ZIP _____	City, State, ZIP _____
Primary language, if other than English _____	Phone _____ Fax _____ Key contact _____

<b>This is a</b> <input type="checkbox"/> New Rx <input type="checkbox"/> Refill	<b>Training by</b> <input type="checkbox"/> Prescriber's office <input type="checkbox"/> Pharmacy to facilitate <input type="checkbox"/> Not needed	<b>Ship to / Site of Care</b> <input type="checkbox"/> Prescriber's office <input type="checkbox"/> Patient <input type="checkbox"/> OptiMed Infusion Center <input type="checkbox"/> Other
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Clinical Information	
<b>Diagnosis</b> <input type="checkbox"/> L20.9 Atopic dermatitis, unspecified <input type="checkbox"/> L20.8 Other atopic dermatitis _____ <input type="checkbox"/> L50.1 Idiopathic urticaria <input type="checkbox"/> J82. Eosinophilic Asthma _____ <input type="checkbox"/> Other (include ICD-10) _____	<b>Weight</b> _____ <input type="checkbox"/> lb <input type="checkbox"/> kg <b>Height</b> _____ <input type="checkbox"/> in <b>Allergies</b> _____ <b>Latex allergy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Prior treatments &amp; reason for discontinuation</b> _____ <b>Other notes</b> _____

If ordering any of the following: **Cinqair<sup>®</sup>, Fasentra<sup>™</sup>, Nucala<sup>®</sup>, Xolair<sup>®</sup>:**

**Will this be the patient's first dose?**  Yes  No, date of last dose: \_\_\_\_\_ Previous treatment history and response: \_\_\_\_\_

**History of parasitic infection?**  Yes  No

**Patient history of anaphylactic-type reaction(s)?**  Yes  No If Yes, please describe \_\_\_\_\_

**For XOLAIR/asthma patients -- Positive skin test or in-vitro reactivity to perennial aeroallergen?**  Yes  No **Pre-treatment IgE** \_\_\_\_\_ IU/mL **Date** \_\_\_\_\_

**For NUCALA: Has the patient previously received the shingles vaccines?**  Yes  No (consider vaccination if medically appropriate)

Medication	Directions	Quantity	Refills
<input type="checkbox"/> <b>Cinqair<sup>®</sup></b> 100mg vial(s) (reslizumab) ^	Infuse 3mg/kg in 50mL NaCl 0.9% IV over 20 to 50 minutes every 4 weeks. <b>Supplies:</b> <input type="checkbox"/> No supplies needed, we have on hand <input type="checkbox"/> OptiMed to supply Quantity Sufficient for each dose ordered of the following: One-50mL IV bag of 0.9% Sodium Chloride Injection; Luer Lock syringe and needle; One infusion set with 0.2 micron filter <i>^Administration by a healthcare professional only per labeling.</i>	1 dose	_____
<input type="checkbox"/> <b>Dupixent<sup>®</sup></b> 300mg (dupilumab)	<input type="checkbox"/> <b>Initial:</b> Inject 600mg (2 syringes) SQ at different injection sites on day 1. <input type="checkbox"/> <b>Maintenance:</b> Beginning day 15, inject 300mg SQ every OTHER week.	2 syringes 2 syringes	Zero _____
<input type="checkbox"/> <b>Fasentra<sup>™</sup></b> 30mg (benralizumab) ^	<input type="checkbox"/> <b>Initial:</b> Administer 30mg SQ at week 0, week 4, and week 8. <input type="checkbox"/> <b>Maintenance:</b> Beginning week 16, administer 30mg SQ once every 8 weeks. <i>^Administration by a healthcare professional only. per labeling.</i>	1 syringe 1 syringe	2 refills _____
<input type="checkbox"/> <b>Nucala<sup>®</sup></b> 100mg (mepolizumab)	<input type="checkbox"/> <b>Severe Asthma:</b> Administer 100mg SQ once every 4 weeks. <input type="checkbox"/> <b>Eosinophilic granulomatosis with polyangiitis:</b> Administer 300mg (3 injections) SQ once every 4 weeks. <b>Supplies:</b> <input type="checkbox"/> No supplies needed, we have on hand <input type="checkbox"/> No supplies needed (for prefilled syringes or pens) <input type="checkbox"/> OptiMed to supply Quantity Sufficient for each dose ordered of the following: Sterile Water for Injection, Luer Lock syringe(s) and needle(s) for reconstitution & SQ injection ‡ <input type="checkbox"/> As the prescriber I have confirmed that self-injection by the patient or caregiver is appropriate for this patient (check if ordering for home use and deemed appropriate).	4-week supply of <input type="checkbox"/> pen(s) ‡ <input type="checkbox"/> syringe(s) ‡ <input type="checkbox"/> vial(s) for reconstitution* (admin. by HCP only)	_____
<input type="checkbox"/> <b>Xolair<sup>®</sup></b> 75mg <input type="checkbox"/> <b>Xolair<sup>®</sup></b> 150mg (omalizumab) ^	<b>Dosing:</b> Administer <input type="checkbox"/> 75mg per dose SQ* ... <input type="checkbox"/> 150mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg <input type="checkbox"/> 375mg <b>Frequency:</b> ... every <input type="checkbox"/> 2 weeks <input type="checkbox"/> 4 weeks *Maximum dose of 150mg administered per injection site. <b>Supplies:</b> <input type="checkbox"/> No supplies needed, we have on hand <input type="checkbox"/> No supplies needed (for prefilled syringes) <input type="checkbox"/> OptiMed to supply Quantity Sufficient for each dose ordered of the following: Sterile Water for Injection, Luer Lock syringe(s) and needle(s) for reconstitution & SQ injection <i>^Administration by a healthcare professional only per labeling.</i>	4-week supply of <input type="checkbox"/> syringes <input type="checkbox"/> vials for reconstitution	_____

**Epinephrine orders:** All patients receiving **Nucala<sup>®</sup>** or **Xolair<sup>®</sup>** must have orders for epinephrine (regardless of indication)

<input type="checkbox"/> <b>AUVI-Q<sup>®</sup></b> <input type="checkbox"/> <b>EpiPen<sup>®</sup></b> or <b>EpiPen Jr<sup>®</sup></b> <input type="checkbox"/> <b>Symjepi<sup>™</sup></b>	<b>Select weight/dose:</b> <input type="checkbox"/> ≥ 30kg: 0.3mg <input type="checkbox"/> 15 to 30kg: 0.15mg Inject one injector into outer thigh IM for allergic reaction. Call 911. Patient to bring epinephrine devices to all appointments and always have available following the administration of each dose of (Nucala <sup>®</sup> , Xolair <sup>®</sup> )
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^ Administration by a healthcare professional only. Ship to Provider Office or administer at OptiMed Ambulatory Infusion Center as indicated above.

**Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.