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MedRX Infusion
www.medrxinfusion.com

Allergy/Asthma Referral Form

Administer At: ☐ Patien's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name:_____

First Name:_____

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

2. Prescriber Information

Prescriber Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

NPI# _____ Office Contact:_____

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:_____ Height:_____ Weight:_____

Tried/Failed Meds and Therapies: _____ Negative TB test date:_____

Diagnosis (ICD 10 Code):_____ Number of exacerbations in the last 12 months:_____

4. Prescription Information ☐ DAW1- Dispense as written. Do not substitute for generic

Medication	Dose	Directions	Dispense	Refill
☐ **Cinqair**	☐ 3 mg/kg = _____ mg available as 100 mg/10 mL vial	Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes	_____ Vials	
☐ **Dupixent**	☐ 100 mg/0.67ml (2-PF Syringe) ☐ 200 mg/1.14mL (2-PF Syringe) ☐ 300 mg/2 mL (2-PF Syringe) ☐ 200 mg/1.14mL (2-PF Pen) ☐ 300 mg/2mL (2-PF Pen)	<u>Initial dose</u> ☐ Inject 400 mg SC (2-200 mg injections in different Inj sites) initially then 200 mg SC every other week ☐ Inject 600 mg SC (300mg in two different Inj sites) initially then 300 mg SC every other week <u>Maintenance Dose:</u> ☐ Inject 200 mg SC every other week ☐ 300 mg SC every other week <u>Chronic Sinusitis with Nasal Polyposis</u> ☐ Inject 300 mg (one injection) SC every other week		
☐ **Fasenra**	☐ 30 mg/mL pre-filled syringe ☐ Auto-injector 30 mg/mL Pen/ Self-administered	☐ Administer 30 mg/mL by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter Other: Administer _____		
☐ **Nucala**	☐ Vial 100 mg vial ☐ PEN 100 mg/mL Auto-injector ☐ PFS 100 mg/mL pre-filled syringe	☐ Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen ☐ Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen		
☐ **Tezspire**	☐ 210 mg/1.91 mL (110 mg/mL) PFS ☐ 210 mg/1.91 mL (110 mg/mL) VIAL	Inject 210 mg SC once every 4 weeks in MD office		
☐ **Xolair**	☐ 75 mg PFS ☐ 150 mg PFS ☐ 150mg Reconstitute Vial (1.2ml)	☐ To be administered: By a healthcare professional ☐ In the Home. Self-administered in the home, patient received at least 3 doses of Xolair, under HCP guidance, with no hypersensitivity reactions. DOSE: _____ every _____ weeks		
☐ **Epipen / Epinephrine**	☐ Epipen 0.3mg autoinjector ☐ Epipen Jr 0.15mg autoinjector	Use as directed.		
☐ **Other**				

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____