Asthma & Allergy Therapies

Referring Physician Orders Rev. 01/2025ss
Contact us with questions at: 804-442-3558 or email: referrals@theinfusionsolution.com
Please fax completed referral form & all required documents to 804-554-584

INFUSION SOLUTIONS

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Moderate Asthma (J45.40-J45.42), ICD 10 _____
☐ Severe Asthma (J45.50-J45.52), ICD 10 _____
☐ Unspecified Asthma (J45.901-J45.909), ICD 10 _____
☐ Other: _____, ICD 10 _____

☐ Nasal Polyps (J33.0-J33.9), ICD 10 _____
☐ Idiopathic Urticaria (L50.1)
☐ Other Urticaria (L50.8)
☐ Unspecified Urticaria (L50.9)

☐ Allergy to peanuts (Z91.010)
☐ Allergy to milk products (Z91.011)
☐ Allergy to eggs (Z91.012)
☐ Allergy to seafood (Z91.013)
☐ Allergy to other foods (Z91.018)

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Fasenra® (benralizumab)	☐ 10 mg ☐ 30 mg	☐ **INITIAL:** Inject SUBQ every 4 weeks x 3 doses, then every 8 weeks x 1 year ☐ **MAINTENANCE:** Inject SUBQ every 8 weeks x 1 year ☐ Observe patient for 1 hour after each dose.
Nucala® (mepolizumab)	100 mg	☐ Inject SUBQ every 4 weeks x 1 year ☐ Observe patient for 1 hour after each dose.
Tezspire® (tezepelumab)	210 mg	☐ Inject SUBQ every 4 weeks x 1 year ☐ Observe patient for 30 minutes after each dose.
Xolair® (omalizumab)	☐ _____ mg ☐ Calculate dose and frequency per patient weight and IgE level	☐ Inject SUBQ every _____ weeks x 1 year ☐ New patient: Observe patient for 2 hour following first Xolair doses, and then for 30 minutes after all subsequent doses. ☐ Established patient: Observe patient for 30 minutes after each dose.

****For drug doses that are calculated based on patient weight, a new order will be requested for weight changes of +/- 5 kgs.**

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time
☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV
☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Test/Lab Results for Asthma diagnosis (required)

☐ Pre-treatment serum eosinophil level (for IL-5 drugs)
☐ Pre-treatment Pulmonary function test (FEV-1 <80% predicted)
☐ Other: _____
☐ Pre-treatment IgE level (for Xolair)
☐ Positive skin or RAST test to a perennial aeroallergen (for Xolair)
☐ Other: _____

Test/Lab Results for Urticaria diagnosis (required)

☐ Baseline Urticaria Activity Score
☐ Other: _____

Test/Lab Results for Food Allergy diagnosis (required)

☐ Pre-treatment IgE level
☐ Positive skin prick or RAST test to a food allergen
☐ Oral food challenge
☐ Other: _____

Prior Failed Therapies

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____