

ASTHMA REFERRAL FORM

Phone (888) 370.1724
Fax (855) 370.0086



Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information		
Last Name	First Name	DOB	Practice/Facility Name					
Address			Address					
City	State	ZIP	City	State	ZIP			
SSN	Allergies		Prescriber Name					
Sex Male Female	Weight (kg)	Height (ft,in)	Prescriber NPI					
Emergency Contact		Phone	Nurse/Key Contact		Phone/Pager			
Insurance Plan	Plan ID #		Fax					

Prescriber Specialty: Allergist Pulmonologist ENT Primary Care Pediatrician Dermatologist Other:

Diagnosis/Clinical Information FOR APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA OR CIU

ICD-10-CM: J45.40 Moderate persistent asthma, uncomplicated J45.50 Severe persistent asthma, uncomplicated
L50.1 Idiopathic urticaria Other:

Concomitant therapies (check all that apply): Short acting beta agonist Long acting beta agonist Systemic glucocorticoids
H1 Antihistamines Decongestants Immunotherapy Inhaled corticosteroid Leukotriene modifiers Nasal steroids
Proton pump inhibitor H2 antagonist Other:

Allergic Asthma: History of positive skin or RAST test to a perennial aeroallergen Symptoms inadequately controlled with ICS
Pretreatment serum IgE level: _____ IU/mL Test date: ____/____/____
Pretreatment FEV1 (if available): _____% Date obtained: ____/____/____
Eosinophil levels (if available): _____ cells/mcL Test date: ____/____/____
Number of severe exacerbations in the past 12 months _____

Chronic Idiopathic Urticaria: Patient has had CIU for 6 weeks or more

Prescription type: Naive/New Start Restart Continued Treatment Last Injection Date: / /

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
Xolair - Allergic Asthma Every FOUR weeks dosing. <i>(dose dependent on weight and IgE levels)</i>	150mg single use vials Current weight: _____kg Weight date: ____/____/____	Administer 75mg/dose every 4 weeks Administer 150mg/dose every 4 weeks Administer 225mg/dose every 4 weeks Administer 300mg/dose every 4 weeks Other: Administer _____mg/dose every 4 weeks		
Xolair - Allergic Asthma Every TWO weeks dosing. <i>(dose dependent on weight and IgE levels)</i>	150mg single use vials Current weight: _____kg Weight date: ____/____/____	Administer 225mg/dose every 2 weeks Administer 300mg/dose every 2 weeks Administer 375mg/dose every 2 weeks Other: Administer _____mg/dose every 2 weeks		
Xolair - CIU Every FOUR weeks dosing. <i>(fixed dose, not dependent on weight or IgE)</i>	150mg single use vials	Administer 150mg/dose every 4 weeks Administer 300mg/dose every 4 weeks Other: Administer _____mg/dose every 4 weeks		
EpiPen		Use as directed	2	
EpiPen Jr.		Use as directed	2	

Do you require diluent and supplies? No Yes – 10mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringe as needed for reconstitution, 18 gauge needles as needed for reconstitution; 25 gauge needles as needed for administration

Date needed: ____/____/____ Medication delivery to (choose one): Prescriber Other:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (Date) DISPENSE AS WRITTEN/Do Not Substitute (Date)

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