# Allergy/Immunology Referral Form

Please fax completed referral form to ivira:
**(302) 499-8729**

Please contact office for questions:
(302) 499-8727

## PATIENT DEMOGRAPHICS:

PATIENT NAME: ____________________ PREFERRED CONTACT #: ____________________

DATE OF REFERRAL: ____________________ GENDER: ☐ F ☐ M

SOCIAL SECURITY NUMBER: ____________________ ADDRESS: ____________________

DATE OF BIRTH: ____________________ CITY, STATE, ZIP: ____________________

## PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ D83.9 Immunodeficiency, common variable
☐ J45.5 - Severe persistent asthma
☐ L50.___ Urticaria
☐ E88.01 - Alpha-1 antitrypsin deficiency
☐ J45.40 - Moderate persistent asthma

## PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

| PRIOR THERAPY (if any): | APPROX START DATE: | APPROX. END DATE: | REASON FOR DISCONTINUATION: |
|---|---|---|---|
| | | | |
| | | | |

## PATIENT INFORMATION:

ALLERGIES: ☐ NKDA ____________________

HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg

## PATIENT CONSENT & AUTHORIZATION:

I hereby authorize Ivira to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

▶▶▶▶▶▶▶▶ ____________________

PATIENT SIGNATURE:

## REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back)
☐ 2. PATIENT DEMOGRAPHICS
☐ 3. MOST RECENT LABS
☐ 4. H & P
☐ 5. LABS FROM TESTING RESULTS SECTION BELOW

## MEDICATION WASTE:

Authorized to round up to nearest vial size?

☐ YES ☐ NO

## TESTING RESULTS:

*FOR CINQUAIR:*

PT WEIGHT: ____________
EOSINOPHIL COUNT: _________
DATE: ________

*FOR FASENRA:*

EOSINOPHIL COUNT: ____________
DATE: ____________

*FOR NUCALA:*

EOSINOPHIL COUNT: ____________
DATE: ____________

*FOR XOLAIR:*

ALLERGY TEST DATE: ____________
IgE LEVEL: ____________
DATE: ____________

## PRN & PREMEDICATIONS:

| MEDICATIONS | 30 minutes prior every infusion | PRN |
|---|---|---|
| Acetaminophen ____ mg PO | ☐ | ☐ PRN every ____ hours for mild or moderate infusion reaction. |
| Diphenhydramine ____ mg PO | ☐ | ☐ PRN every ____ hours for mild or moderate infusion reaction. |
| Diphenhydramine ____ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 minutes. | ☐ | ☐ PRN every ____ hours for mild or moderate infusion reaction. |
| Methylprednisolone ____ mg IV push over 5 minutes. | ☐ | |
| Methylprednisolone 100mg IV | ☐ | |

## ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☐ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER GREENHILL INFUSION POLICY AND PROCEDURE (See Reverse Side)

☐ OTHER: (please fax other reaction orders if checking this box)

# Allergy/Immunology Referral Form



## MEDICATION SELECTION:

| Medication | Details | Refills |
|---|---|---|
| CINQAIR® (reslizumab) injection | **TESTING:** PT WEIGHT:__________ EOSINOPHIL COUNT:__________ DATE:____________<br>**DOSE:** ☐ 3 MG/KG IV EVERY 4 WEEKS<br>**ALTERNATE DOSE:** ☐ ________________________________________________ | REFILLS:______ |
| DUPIXENT® (dupilumab) | **INITIAL DOSE:** ☐ 400 MG SC *or* ☐ 600 MG SC<br>**MAINTENANCE:** ☐ 200 MG SC QOW *or* ☐ 300 MG SC QOW | REFILLS:______ |
| Fasenra® (benralizumab) Subcutaneous Injection 30 mg | **TESTING:** EOSINOPHIL COUNT:__________ DATE:____________<br>**DOSE:** ☐ 3 DOSES OF 30 MG SC EVERY 4 WEEKS, THEN 30 MC SC EVERY 8 WEEKS | REFILLS:______ |
| Nucala (mepolizumab) | **TESTING:** EOSINOPHIL COUNT:__________ DATE:____________<br>**DOSE:** ☐ 100 MG SC EVERY 4 WEEKS | REFILLS:______ |
| PROLASTIN® C alpha$_1$-proteinase inhibitor (human) | **DOSE:** ☐ 60 MG/KG EVERY WEEK | REFILLS:______ |
| Xolair® Omalizumab | **TESTING:** ALLERGY TEST DATE:___________ IgE LEVEL:______________ DATE:___________<br>**DOSE:** ☐ ______ MG SC EVERY ______ WEEKS | REFILLS:______ |
| IMMUNOGLOBULIN THERAPY | **BRAND:** ☐ NO PREFERENCE ☐ GAMUNEX ☐ OCTAGAM ☐ _______________<br>**DOSING:** ☐ ________ GRAMS IV ☐ ________ GRAMS SC<br>**DIRECTIONS:** ________________________________________________ | REFILLS:______ |

## EPINEPHRINE SELECTION:

| Product | Directions | Quantity |
|---|---|---|
| ☐ AUVI-Q®<br>☐ EPIPEN®<br>☐ EPIPEN® Jr. | ☐ INJECT ONE INJECTOR INTO OUTER THIGH IM FOR ANAPHYLAXIS. PRESS FIRMLY FOR 5 SECONDS. CALL 911. | ☐ 1 KIT (2 INJECTORS) |
| | ☐ INJECT ONE INJECTOR INTO OUTER THIGH IM FOR ANAPHYLAXIS. MAY REPEAT ONE TIME AFTER ______ MINUTES . CALL 911. | ☐ 2 KITS (4 INJECTORS)<br>REFILLS:______ |

## PRESCRIBER INFORMATION:

| | |
|---|---|
| PHYSICIAN NAME: | PHONE: |
| OFFICE CONTACT: | FAX: |
| ADDRESS: | LICENSE #: |
| CITY, STATE, ZIP: | NPI: |

PHYSICIAN SIGNATURE: DATE: