



STAT REFERRAL

ASTHMA AGENTS

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ kg Sex: () Male () Female Allergies: () NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

Date of Diagnosis: _____

PRESCRIPTION ORDERS

- a) WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY 10 %
- b) Pretreatment Serum IgE (Xolair) _____

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	XOLAIR	<input type="checkbox"/> 150mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg <input type="checkbox"/> 375mg	SQ	Every _____ days	
	FASENRA (LOADING DOSES)	30mg	SQ	Every 4 weeks for 3 doses, then every 8 weeks	
	FASENRA (MAINTANENCE DOSES)	30mg	SQ	Every 8 weeks	

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	NONE	NA	NA
	BMP	() PRIOR () POST	
	CMP	() PRIOR () POST	
	BUN/CREATININE	() PRIOR () POST	
	CRP:	() PRIOR () POST	
	ESR:	() PRIOR () POST	
	Other:	() PRIOR () POST	

NOTES:

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.