DeliverIt Pharmacy Infusion & Specialty

Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478

Allergy Immuno Infusion Orders

F: 832.939.8128 T: 832.939.8137

PATIENT INFORMATION

Patient Name: ______________________________ Social Sec #: ____________ Weight: ____ lbs

D.O.B: ____________ Sex: Male ____ Female _____ Height: ____ lbs

Phone: __________________

Address: ____ City: __________ State: ____ Zip Code: __________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis Date: _______ **ICD-10:** _______ **Allergies**: ____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

History of Allergic Asthama (Xolair): Positive Skin or RAST Test ☐Yes ☐ No Test Date: _______

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physcian

Required Labs: ☐ CBC with differential (Cinqair, Fasenra and Nucala) ☐ BMP or Cr (IVIG)

Lab Orders: ____

*__Note:__ Patient must have their EpiPen in their possession at every Xolair appointment

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐Allergic Asthama ICD-10 ________ ☐Diverticulitis ICD-10 ________	☐ **Xolair** 150mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for ____ months ☐ **Xolair** 225mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for ____ months ☐ **Xolair** 300mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for ____ months ☐ **Xolair** 375mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for ____ months	☐ ________ ☐ x 1 year
☐Severe Allergic Asthama with Eosinophilic phenotype ICD-10 ________ ☐Eosinophilic Granulomatosis With Polyan giitis ICD-10 ________	☐**Cinqair** 3mg/kg IV every 4 weeks for ____ months ☐**Fasenra** initial dose: 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30mg Sub-Q every 8 weeks thereafter for ____ months ☐**Fasenra** maintenance dose: 30mg Sub-Q every 8 weeks for ____ months ☐**Nucala** 100mg Sub-Q every 4 weeks for ____ months ☐**Nucala** 300mg Sub-Q every 4 weeks for ____ months	☐ ________ ☐ x 1 year
☐Common Variable Immunodeficiency ICD-10 ________ ☐Other:________ ICD-10 ________	**IVIG Brand:** ☐ Bivigam ☐ Cytogam ☐ Gammagard ☐ Gammamaked ☐ Gammaplex ☐ Gamunex C ☐ Octagam ☐ Privigen **IVIG Pre-medication Orders:** ☐ Tylenol 1000mg Antihistamine: ☐ Cetrizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO **Additional Pre-Medication Orders:** ☐ Solu-Medrol ___mg IVP ☐ NS 0.9% ____ml IV ☐ **IVIG** Order: ____mg/kg IV over ____ day(s) ☐ **IVIG** Order: ____gm/kg IV over ____ day(s) **Frequency:** ☐ Every ___ weeks for ___ months or ☐ One-time dose ONLY	☐ ________ ☐ x 1 year
	Hypersensitivity/Anaphylaxis Response Protocol PRN	

PHYSICIAN INFORMATION

By signing this form and utilizing your services, you are authorizing DeliverIt Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ______________________________ Date: __________________

Physician Name: ________________________________

Phone: ______________ Fax: ______________ Contact Person: ________________