

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location _____

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ ☐ LBS ☐ Kg Gender ☐ M ☐ F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION:

- ☐ Allergic Asthma _____
- ☐ Severe Asthma _____
- ☐ CIU _____
- ☐ Other _____
- ☐ Eosinophilic Asthma _____

DOSING

- ☐ Administer _____mg at _____mg/kg IV every 4 weeks OR
- ☐ Administer _____
- ☐ Vital signs per HI Protocol
- ☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
- ☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
- ☐ Prednisone _____ mg PO
- ☐ Other _____

POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Prednisone _____ mg PO
- ☐ Other _____

LABS

- ☐ CBC w/Diff ☐ Each Infusion ☐ Other Frequency (specify): _____
- ☐ CRP ☐ Each Infusion ☐ Other Frequency (specify): _____
- ☐ CMP ☐ Each Infusion ☐ Other Frequency (specify): _____
- ☐ ESR ☐ Each Infusion ☐ Other Frequency (specify): _____
- ☐ Hepatic Panel ☐ Each Infusion ☐ Other Frequency (specify): _____
- ☐ Renal Panel ☐ Each Infusion ☐ Other Frequency (specify): _____
- ☐ Quantiferon TB Gold, annually, last completed (date): _____
- ☐ Other (specify): _____

Provider Signature _____ Date _____

For new referrals, please include recent labs and last two office visit notes.

Fax Referrals to: Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586