AYSA
THERAPEUTICS INFUSION CENTER

ALLERGY & IMMUNOLOGY ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

Diagnosis Date: _____ ICD-10: _____

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

History of Asthma (Xolair): Positive Skin or RAST Test: ☐ Yes ☐ No ** *Required for Asthma* Test Date: _____

Pre-Treatment IgE Serum: _____ IU/ml ** *Required for Asthma and Nasal Polyp* Test Date: _____ Date of last Xolair Dose: _____

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

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
☐ Persistent Asthma ICD-10 _____ ☐ Chronic Idiopathic Urticaria ICD-10 _____ ☐ Nasal Polyps 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 ☐ Xolair _____ mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months	☐ _____ ☐ x1 year
☐ Severe Asthma with Eosinophilic phenotype ICD-10 _____ ☐ Eosinophilic Granulomatosis with Polyangiitis 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 30 mg 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	☐ _____ ☐ x1 year
☐ Common Variable Immunodeficiency ICD-10 _____ ☐ Other: _____ ICD-10 _____	IVIG Brand: ☐ Bivigam ☐ Carimune _____ % ☐ CytoGam ☐ Flebogamma 5% ☐ Flebogamma 10% ☐ Gammagard ☐ Gammaked ☐ Gammaplex ☐ Gamunex C ☐ Octagam ☐ Panzyga ☐ Privigen IVIG Pre-medication Orders: ☐ Tylenol 1000mg Antihistamine: ☐ Cetirizine 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	☐ _____ ☐ x1 year

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____