FLEXCARE INFUSION CENTERS

ASTHMA REFERRAL FORM

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_______________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

• For Xolair: Positive skin test or in vitro reactivity to a perennial aeroallergen? ☐ Y ☐ N Date of test:______________
• For renewal requests: What is the patient's most recent Eosinophil count _______ Date of test:______________
Did the patient experience measurable improvement in disease activity and/or severity? ☐ Y ☐ N (provide documentation)

PRIMARY DIAGNOSIS

☐ J45.40 Moderate persistent asthma, uncomplicated
☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.51 Severe persistent asthma with (acute) exacerbation
☐ J45.901 Unspecified asthma with (acute) exacerbation
☐ J45.901 Unspecified asthma with (acute) exacerbation
☐ J82.83 Eosinophilic asthma
☐ Other: ____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ______________________________

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds
☐ Provider Prescribed: ______________________________________

PRIMARY MEDICATION ORDER

☐ Xolair ________mg SubQ Injection every 2 weeks
☐ Xolair ________mg SubQ Injection every 4 weeks
☐ Tezspire 210mg SubQ Injection every 4 weeks
☐ Fasenra 30mg SubQ Injection at week 0, 4, 8, and every 8 weeks thereafter
☐ Nucala 100mg SubQ Injection every 4 weeks
☐ Cinqair 3mg/kg (_______mg) IV every 4 weeks
☐ Other: ____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: ______________________________

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

______________________________________ ______________________
Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

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