ALLERGY/IMMUNOLOGY ORDER SET

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□ lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing		Refills
Immunoglobulin	□ **IV** □ **SubQ** _____mg/kg **OR** _____ gm/kg x ____ day(s) **OR** divided over ____ day(s) **Frequency**: Every _____ weeks OR _____ (*LIVbetter to choose if not indicated*) Brand: _____ Additional orders: _____		□ _____ □ x1 year
Cinqair (reslizumab)	□ 3mg/kg IV every 4 weeks		□ _____ □ x1 year
Fasenra (benralizumab)	□ 30mg SubQ every 4 weeks for the first 3 doses followed by 30mg SubQ every 8 weeks thereafter □ 30mg SubQ every 4 weeks □ 30mg SubQ every 8 weeks		□ _____ □ x1 year
Nucala (mepolizumab)	□ 100mg SubQ every 4 weeks □ 300mg SubQ every 4 weeks		□ _____ □ x1 year
Tezspire (tezepelumab)	□ 210mg SubQ every 4 weeks		□ _____ □ x1 year
Xolair (omalizumab)	□ 75mg SubQ □ 150mg SubQ □ 225mg SubQ □ 300mg SubQ □ 375mg SubQ □ 450mg SubQ □ 525mg SubQ □ 600mg SubQ	□ Every 2 weeks □ Every 4 weeks □ _____	□ _____ □ x1 year

Pre-medication orders: Acetaminophen □ 1000mg □ 500mg PO, please choose one antihistamine (if indicated):
□ Diphenhydramine 25mg PO □ Loratadine 10mg PO □ Cetirizine 10mg PO □ Cetirizine 10mg IVP

Additional pre-medications: □ Solu-Medrol _____ mg IVP □ Solu-Cortef _____ mg IVP

□ Other _____

Lab orders: _____ **Frequency:** □ Every infusion □ Other: _____

Required labs to be drawn by: □ LIVbetter □ Referring provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR ALLERGY/IMMUNOLOGY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Please indicate any tried and failed therapies (if applicable):
    - ☐ Corticosteroids _____
    - ☐ Long acting beta 2 agonist _____
    - ☐ Long acting muscarinic antagonist _____
    - ☐ Immunosuppressants (EGPA) _____
  - ☐ *Asthma* - Does the patient have a history of 2 exacerbations requiring a course of oral/ systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? ☐ Yes ☐ No
  - ☐ *Asthma* - Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? ☐ Yes ☐ No
  - ☐ *PI* - Documentation of recurrent bacterial infections,history of failure to respond to antibiotics documentation of pre and post pneumococcal vaccine titers
- ☐ Include labs and/or test results to support diagnosis **(attach results)**
  - ☐ Does patient have a baseline peripheral blood eosinophil level of ⩾ 150 cells/mcL within the past 6 weeks (*asthma & EGPA*) or ⩾ 1000 cells/mcL within 4 weeks (*HES*)? ☐ Yes ☐ No
  - ☐ FEV1 score (if applicable): _____
  - ☐ Serum IgE level - *for asthma & nasal polyps Xolair*
  - ☐ Skin/RAST test - *for asthma Xolair*
  - ☐ Serum immunoglobulins - *for Ig*
  - ☐ Serum creatinine - *for Ig*
  - ☐ CBC w/differential - *for Fasenra, Nucala, Cinqair*
- ☐ If injection order, is the patient or caregiver not competent or physically unable to administer theproduct for self-administration? ☐ Yes ☐ No
- ☐ Xolair - Patient has Epi pen prescribed
- ☐ Other medical necessity: _____