

PATIENT

PATIENT NAME		DATE OF BIRTH	PHONE
ADDRESS		CITY / STATE / ZIP	EMAIL
WEIGHT _____ ☐ kg ☐ lb	HEIGHT _____ ☐ cm ☐ in	ALLERGIES	PATIENT STATUS ☐ New ☐ Continuing

DIAGNOSIS ICD-10 required — check one or write it in

☐ J45.50 Severe persistent asthma	☐ M30.1 EGPA (Churg-Strauss)	☐ D83.9 Common variable immunodeficiency
☐ J45.40 Moderate persistent asthma	☐ D72.110 Idiopathic hypereosinophilic syn.	☐ D80.1 Nonfamilial hypogammaglobulinemia
☐ J33.0 Polyp of nasal cavity	☐ L50.1 Chronic idiopathic urticaria	☐ J44.9 COPD, unspecified
☐ J33.9 Nasal polyp, unspecified	☐ L20.84 Intrinsic atopic dermatitis	☐ J30.1 Allergic rhinitis due to pollen
☐ J32.4 Chronic pansinusitis	☐ K20.0 Eosinophilic esophagitis	☐ Z91.010 / .011 / .012 / .013 Food allergy
OTHER ICD-10	DIAGNOSIS DESCRIPTION	

PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX
OFFICE CONTACT	EMAIL	NEXT TREATMENT DATE	TAX ID
PRIMARY INSURANCE	POLICY #	GROUP #	
SECONDARY INSURANCE	POLICY #	GROUP #	

PRIOR THERAPY check and name the agent

☐ Inhaled or systemic corticosteroids: _____
☐ Long-acting beta-2 agonist: _____
☐ Long-acting muscarinic antagonist: _____
☐ Antihistamines, including above-label dosing: _____
☐ Immunosuppressants, for EGPA: _____
☐ Prior biologic, and why it was stopped: _____

REQUIRED PRE-SCREENING attach all results

☐ Blood eosinophil count. _____ cells/mcL Date: _____ ≥ 150 within 6 weeks for asthma and EGPA · $\geq 1,000$ within 4 weeks for HES
☐ Serum total IgE. _____ IU/mL Date: _____ required for Xolair in asthma and nasal polyps — not needed for urticaria
☐ Skin test or in vitro reactivity to a perennial aeroallergen. ☐ Positive ☐ Negative required for Xolair in asthma
☐ CBC with differential. required for Fasenra, Nucala and Cinqair
☐ Serum immunoglobulins. ☐ Serum creatinine. both required for immunoglobulin
☐ Pulmonary function tests attached. FEV1: _____ %
☐ Two or more exacerbations needing oral steroids, hospitalization or an ER visit in 12 months. Number: _____
☐ ACQ score above 1.5, or ACT score consistently below 20. Score: _____
☐ Primary immunodeficiency — recurrent bacterial infections, failure to respond to antibiotics, and pre- and post-pneumococcal vaccine titers documented
☐ Is the patient or caregiver unable to self-administer? ☐ Yes ☐ No ☐ Candidate for home therapy? ☐ Yes ☐ No

BEFORE THE FIRST DOSE — DRUG-SPECIFIC

Cinqair boxed warning	Anaphylaxis occurred in 0.3% of patients in trials and can be life-threatening. Give in a healthcare setting with a provider prepared to manage it, observe the patient afterward, and stop permanently if it occurs. Adults 18 and older only.
Xolair boxed warning	Anaphylaxis can occur after the first dose or after more than a year of treatment. Observe after each dose. ☐ Patient has an epinephrine auto-injector in their possession on each appointment date
All biologics	None of these treat acute bronchospasm or an exacerbation — continue rescue and controller inhalers. Do not stop corticosteroids abruptly; taper gradually under the referring prescriber. Treat any pre-existing helminth infection first.

PATIENT NAME	DATE OF BIRTH

SELECT ONE MEDICATION route and infusion time shown under each drug — for chair scheduling

DRUG	DOSE & SCHEDULE	REFILL
Cinqair <i>reslizumab</i> IV • 20–50 min	☐ 3 mg/kg IV every 4 weeks severe eosinophilic asthma, adults 18 and older only Boxed warning for anaphylaxis — see page 1. Not for other eosinophilic conditions.	☐ × 1 year ☐ _____
Fasenra <i>benralizumab</i> SubQ	☐ Asthma, age 12+: 30 mg every 4 weeks for the first 3 doses, then every 8 weeks ☐ Asthma, age 6–11, under 35 kg: 10 mg on the same schedule — 3 doses q4w, then q8w ☐ Asthma, age 6–11, 35 kg or more: 30 mg on the same schedule — 3 doses q4w, then q8w ☐ EGPA (adults) or HES (age 12+): 30 mg every 4 weeks — no loading doses, stays every 4 weeks	☐ × 1 year ☐ _____
Nucala <i>mepolizumab</i> SubQ	☐ 100 mg every 4 weeks asthma age 12+, nasal polyps, COPD ☐ 40 mg every 4 weeks asthma age 6 to 11 ☐ 300 mg every 4 weeks EGPA or HES — given as three 100 mg injections at least 5 cm apart	☐ × 1 year ☐ _____
Tezspire <i>tezepelumab-ekko</i> SubQ	☐ 210 mg every 4 weeks severe asthma or chronic rhinosinusitis with nasal polyps, age 12 and older	☐ × 1 year ☐ _____
Xolair <i>omalizumab</i> SubQ	Dose: ☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg ☐ 450 mg ☐ 525 mg ☐ 600 mg Frequency: ☐ every 2 weeks ☐ every 4 weeks asthma, polyps and food allergy are dosed from pre-treatment IgE + weight ☐ Chronic spontaneous urticaria: 150 mg or 300 mg every 4 weeks — no IgE or weight needed	☐ × 1 year ☐ _____
Exdensus <i>depemokimab-ulaa</i> SubQ • in clinic	☐ 100 mg every 6 months severe eosinophilic asthma, age 12 and older Provider-administered only — the label does not permit self-administration. First dose: _____ Next due: _____	☐ × 1 year ☐ _____
Dupixent <i>dupilumab</i> SubQ	☐ Asthma, age 12+: 400 mg load then 200 mg q2w OR 600 mg load then 300 mg q2w ☐ Nasal polyps, age 12+: 300 mg every 2 weeks ☐ COPD, adults: 300 mg every 2 weeks ☐ Chronic spontaneous urticaria, adults: 600 mg load then 300 mg q2w ☐ Eosinophilic esophagitis, 40 kg or more: 300 mg weekly <i>Paediatric and weight-based dosing is on the Dupixent order set — please use that form.</i>	☐ × 1 year ☐ _____
Immunoglobulin <i>IVlg / SCIg</i> IV or SubQ	Route: ☐ IV ☐ SubQ Dose: _____ ☐ g/kg ☐ mg/kg Frequency: every _____ weeks ☐ Divide over _____ days ☐ LIVbetter to select product per coverage Brand: _____	☐ × 1 year ☐ _____
Other	Drug: _____ Dose: _____ Route: _____ Frequency: _____	☐ × 1 year ☐ _____

PRE-MEDICATIONS & LABS

Pre-meds	☐ Acetaminophen ☐ 500 ☐ 1,000 mg PO ☐ Diphenhydramine 25 mg ☐ PO ☐ IV ☐ Loratadine 10 mg PO ☐ Cetirizine 10 mg PO ☐ Methylprednisolone _____ mg IV ☐ Solu-Cortef _____ mg IV ☐ Other: _____
Labs	Orders: _____ Frequency: ☐ Every infusion ☐ Other: _____ Observation after each dose: _____ minutes Drawn by: ☐ LIVbetter ☐ Referring provider

PRESCRIBER SIGNATURE required — we cannot schedule without it

By signing, you authorize LIVbetter Infusions to act as your prior authorization and specialty pharmacy designated agent with insurance companies and to select the site of care. Where your state requires it, check "Dispense as written" to prevent generic substitution.

PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

SEND WITH EVERY REFERRAL

- ☐ Signed and completed order — pages 1 and 2
- ☐ Patient demographic and insurance information
- ☐ Current medication list
- ☐ Clinical notes covering tried and failed therapies, intolerance, or contraindication to conventional therapy
- ☐ Labs and test results supporting the diagnosis
- ☐ Other medical necessity: _____