INFUSE ONE

Email to: intake@infuseone.com
Fax to: 888-261-6644

☐ Palm Beach Gardens
☐ Melbourne
☐ Tallahassee
☐ Fort Lauderdale

Pulmonary Referral Form

Last Name, First Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F ☐ Other

Address: _____ City, State, Zip: _____

Phone: _____ SSN# _____

Referring Practice: _____

Practice Address: _____ City, State, Zip: _____

Prescriber Name: _____ Prescriber NPI: _____

Nurse/Key Contact: _____ Phone: _____

Fax: _____ Email: _____

Nursing & Lab Orders

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion.
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed *Heparin* -☐ 10units/mL ***---OR---*** ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line
Lab Orders: _____ **Lab Date & Frequency**: _____

Prescription Orders

Anaphylaxis Kit: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply) ☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

Pre-Medications: ☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol ____mg IV __minutes prior to infusion
(Check all that apply) ☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion ☐ Other

Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

Prescription Information

PRODUCT	DIRECTIONS	REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____		
☐ Aralast	60mg/kg IV infusion weekly over approximately 15 minutes **Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch*	
☐ Cinqair	3mg/kg IV infusion once every 4 weeks over 20-50 minutes	
☐ Fasenra	☐ **INDUCTION:** 30mg SubQ injection every 4 weeks for the first 3 doses	NONE
	☐ **MAINTENANCE:** 30mg SubQ injection once every 8 weeks	
☐ Glassia	60mg/kg IV infusion over approximately 15 minutes **Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch*	
☐ Nucala	☐ 100mg SubQ injection every 4 weeks ☐ 300mg SubQ injection every 4 weeks	
☐ Tezspire	210mg SubQ injection once every 4 weeks	
☐ Xolair	_____mg SubQ injection every _____weeks	
☐ Other		

By signing this form and utilizing our services, you are authorizing Infuse One to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

DISPENSE AS WRITTEN
Prescriber's Signature: _____ Print Name: _____ Date: _____

SUBSTITUTION PERMITTED
Prescriber's Signature: _____ Print Name: _____ Date: _____

Please be sure to attach the following: Provider Phone Line: 833-881-6048

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ Documentation on phenotype (Aralast and Glassia only)
- ☐ Chest x-ray results (Aralast and Glassia only)
- ☐ CT scan results (Aralast and Glassia only)
- ☐ IgA level (Aralast and Glassia only)
- ☐ Eosinophil levels (Fasenra, Cinqair and Nucala only)
- ☐ Alpha-1 antitrypsin levels (Aralast and Glassia only)
- ☐ FEV1 score (Aralast and Glassia only)
- ☐ Current Smoker? ☐ Yes ☐ No (Aralast and Glassia only)
- ☐ Line access documentation/verification if applicable
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines