PULMONARY ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: ____ DOB: ___________________ Phone: ______________________________

MEDICAL INFORMATION

Patient Weight: _____________ lbs./kg. (required) Allergies: ____

THERAPY ORDER

Diagnosis	Infusion Orders		Refills
☐ Persistent Asthma **ICD-10 Code: __________** ☐ Chronic Idiopathic Urticaria **ICD-10 Code: __________** ☐ Nasal Polyps **ICD-10 Code: __________**	☐ **Xolair** 75mg Sub-Q ☐ **Xolair** 150mg Sub-Q ☐ **Xolair** 225mg Sub-Q ☐ **Xolair** 300mg Sub-Q ☐ **Xolair** 375mg Sub-Q ☐ **Xolair** 450mg Sub-Q ☐ **Xolair** 525mg Sub-Q	**Xolair frequency:** ☐ Every 2 weeks ☐ Every 4 weeks ****Patient must have EpiPen prescription****	☐ ____________ ☐ x 1 year
☐ Severe Asthma w/ Eosinophilic phenotype **ICD-10 Code: __________** ☐ Severe Granulomatosis w/ Polyangiitis **ICD-10 Code: __________**	☐ **Cinqair** 3mg/kg IV every 4 weeks ☐ **Fasenra** initial dose: 30mg SubQ every 4 weeks for the first 3 doses followed by 30mg SubQ every 8 weeks thereafter ☐ **Fasenra** maintenance dose: 30mg SubQ every 8 weeks ☐ **Nucala** 100mg SubQ every 4 weeks ☐ **Nucala** 300mg SubQ every 4 weeks ☐ **Tezspire** 210mg SubQ every 4 weeks		☐ ____________ ☐ x 1 year
☐ Alpha-1 Antitrypsin Deficiency **ICD-10 Code: _______ (E88.01)**	☐ **Prolastin** 60mg/kg IV weekly ☐ **Glassia** 60mg/kg IV weekly ☐ Other: ____		☐ ____________ ☐ x 1 year
☐ Other: ______________ **ICD-10 Code: __________**	☐ Other: ____		☐ ____________ ☐ x 1 year

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: ______________________________ Signature: ______________________________ Date: __________________

Provider NPI: ______________________ Phone: ______________________ Fax: ___________________ Contact Person: _______________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.