



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

ACTIVEINFUSIONS.COM

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.

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

Phone Call Text Message Email No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder?

Yes No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION