VEROS HEALTH
Excellence in Complex Care

ASTHMA REFERRAL FORM

Please complete the following and fax with clinical documentation to: 720.870.2414

Referral Process

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name:	Physician's name:
Address:	License #: NPI #:
City: State: Zip:	DEA #:
Home Phone: Other Phone:	Address:
Email:	City: State: Zip:
DOB: Social Security #:	Office Contact:
Gender: ☐ M ☐ F Height: Weight:	Phone: Fax:
Allergies:	

3. DIAGNOSIS Year of diagnosis: _____

- ☐ Moderate Persistent Asthma (J45.4)
- ☐ Severe Persistent Asthma (J45.5) ☐ Chronic Idiopathic Urticaria (L50.1)
- ☐ Chronic Rhinosinusitis (J32.9) with Nasal Polyposis (J33.9)
- ☐ Severe persistent asthma with (acute) exacerbation (J45.51)
- ☐ Other(s):

4. INSURANCE INFORMATION: Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. ADDITIONAL INFORMATION REQUESTED

Prescription type: ☐ Naive/new start ☐ Restart ☐ Continued therapy

Lab results: ☐ History of positive skin OR RAST test to a perennial aeroallergen IgE Level: _____ IU/mL; date _____

Current/previous history of parasitic (helminth) infections? _____

Concomitant Therapies: ***check all that apply:***

☐ Short acting beta agonist ☐ Long acting beta agonist ☐ Antihistamines ☐ Decongestants
☐ Immunotherapy ☐ Inhaled Corticosteroid ☐ Leukotriene modifiers ☐ Oral steroid ☐ Nasal steroid ☐
Other: _____

6. PRESCRIPTION INFORMATION	Quantity	Refills
☐ **Fasenra™ (benralizumab) 30 mg/1 ml pre-filled syringe** Inject 30 mg (1ml) subcutaneously every 4 weeks for the first 3 doses, followed by 30 mg once every 8 weeks thereafter	_____ syringes ☐ 30-day supply ☐ 90-day supply ☐ _____-day supply	☐ 1 year ☐ _____
☐ **CINQAIR® (reslizumab) – 100 mg/10mL vial** Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes	_____ vials ☐ 30-day supply ☐ 90-day supply ☐ _____-day supply	☐ 1 year ☐ _____

Asthma Adult Dosing ☐ **Dupixent® (dupilumab) 200 mg/1.14 ml prefilled syringe** Initial dose of 400 mg (two 200 mg injections) subcutaneously followed by 200 mg every other week ☐ **Dupixent® (dupilumab) 300 mg/2 ml prefilled syringe** Initial dose of 600 mg (two 300 mg injections) subcutaneously followed by 300 mg every other week **CRSwNP** ☐ **Dupixent® (dupilumab) 300 mg/2 ml prefilled syringe** Recommended dose is 300 mg subcutaneously every other week **Asthma Pediatric Dosing** *For 15 to less than 30 kg*: ☐ 100 mg subcutaneously every 2 weeks **OR** ☐ 300 mg subcutaneously every 4 weeks *For ≥ 30 kg:* ☐ 200 mg subcutaneously every 2 weeks	**Quantity** _____ syringes ☐ 30-day supply ☐ 90-day supply ☐ _____-day supply	**Refills** ☐ 1 year ☐ _____
☐ **Nucala® (mepolizumab) – 100 mg vial** Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen Include sterile water and supplies sufficient for medication administration • One 10 mL vial sterile water for injection for every vial of Nucala® dispensed • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution • 1 mL polypropylene syringe with 21G to 27G x ½" needle for subcutaneous injection ☐ No supplies	**Quantity** ☐ 30-day supply ☐ 90-day supply ☐ _____-day supply	**Refills** ☐ 1 year ☐ _____
☐ **Xolair® (omalizumab) prefilled syringe (*dispense minimal number of 75mg and/or 150mg to complete prescribed dose*)** **OR** ☐ **Xolair® (omalizumab) 150mg single dose vial** **Every 4 weeks dosing:** ❑ Administer 75mg per dose subcutaneously every 4 weeks ❑ Administer 150mg per dose subcutaneously every 4 weeks ❑ Administer 225mg per dose subcutaneously every 4 weeks ❑ Administer 300mg per dose subcutaneously every 4 weeks ❑ Administer 450mg per dose subcutaneously every 4 weeks ❑ Administer 600mg per dose subcutaneously every 4 weeks ❑ Administer other: _____ mg per dose subcutaneously every 4 weeks **Every 2 weeks dosing**: ❑ Administer 225mg per dose subcutaneously every 2 weeks ❑ Administer 300mg per dose subcutaneously every 2 weeks ❑ Administer 375mg per dose subcutaneously every 2 weeks ❑ Administer 450mg per dose subcutaneously every 2 weeks ❑ Administer 525mg per dose subcutaneously every 2 weeks ❑ Administer 600mg per dose subcutaneously every 2 weeks ❑ Administer other: _____ mg per dose subcutaneously every 2 weeks	Xolair® (omalizumab) ❑ Asthma (dose is dependent on weight and IgE levels, see package insert) ❑ CIU (fixed dose, not dependent on weight or IgE) ❑ Nasal Polyposis	**Quantity** ☐ 30-day supply ☐ 90-day supply ☐ _____-day supply **Refills** ☐ 1 year ☐ _____

FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated

☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

☐ Other: _____

Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*

Age 1-5: 12.5mg IV/PO x1 **Age 6-11**: 25mg IV/PO x1 **Age 12+**: 50mg IV/PO x1

For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1. If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

7. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ Date: _____