

Asthma & Allergy Therapies

Referring Physician Orders Rev. 12/2025

Please fax completed referral form & all required documents to 208-595-4427



PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City/ST/Zip: _____
Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

*ICD 10 Code Required

- | | | |
|---|---|---|
| <input type="checkbox"/> Moderate Asthma (J45.40-J45.42), ICD 10 _____ | <input type="checkbox"/> Nasal Polyps (J33.0-J33.9), ICD 10 _____ | <input type="checkbox"/> Allergy to peanuts (Z91.010) |
| <input type="checkbox"/> Severe Asthma (J45.50-J45.52), ICD 10 _____ | <input type="checkbox"/> Idiopathic Urticaria (L50.1) | <input type="checkbox"/> Allergy to milk products, unspecified (Z91.0110) |
| <input type="checkbox"/> Unspecified Asthma (J45.901-J45.909), ICD 10 _____ | <input type="checkbox"/> Other Urticaria (L50.8) | <input type="checkbox"/> Allergy to eggs, unspecified (Z91.0120) |
| <input type="checkbox"/> Other: _____, ICD 10 _____ | <input type="checkbox"/> Unspecified Urticaria (L50.9) | <input type="checkbox"/> Allergy to seafood (Z91.013) |
| | | <input type="checkbox"/> Allergy to other foods (Z91.018) |

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Cinqair® (reslizumab)	<input type="checkbox"/> _____ mg (3 mg/kg)	<input type="checkbox"/> Infuse IV over 20-50 minutes every 4 weeks x 1 year <input type="checkbox"/> Observe patient for 30 minutes after each dose.
Exdensus® (depemokimab)	100 mg	<input type="checkbox"/> Inject SUBQ every 6 months x 1 year <input type="checkbox"/> Observe patient for 1-2 hours after each dose.
Fasenra® (benralizumab)	<input type="checkbox"/> 10 mg <input type="checkbox"/> 30 mg	<input type="checkbox"/> INITIAL: Inject SUBQ every 4 weeks x 3 doses, then every 8 weeks x 1 year <input type="checkbox"/> MAINTENANCE: Inject SUBQ every 8 weeks x 1 year <input type="checkbox"/> Observe patient for 1 hour after each dose.
Nucala® (mepolizumab)	100 mg	<input type="checkbox"/> Inject SUBQ every 4 weeks x 1 year <input type="checkbox"/> Observe patient for 1 hour after each dose.
Tezspire® (tezepelumab)	210 mg	<input type="checkbox"/> Inject SUBQ every 4 weeks x 1 year <input type="checkbox"/> Observe patient for 30 minutes after each dose.
Xolair® (omalizumab)	<input type="checkbox"/> _____ mg <input type="checkbox"/> Calculate dose and frequency per patient weight and IgE level	<input type="checkbox"/> Inject SUBQ every _____ weeks x 1 year <input type="checkbox"/> New patient: Observe patient for 2 hours following first 3 Xolair dose, and then for 30 minutes after all subsequent doses. <input type="checkbox"/> Established patient: Observe patient for 30 minutes after each dose.

Is patient currently receiving therapy above from another facility? NO YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____ ESR q _____ LFTs q _____ Other: _____

PRE-MEDICATION ORDERS:

- No premeds ordered at this time Diphenhydramine 25mg PO
 Acetaminophen 650mg PO Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IV
 Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
Physician Name: _____ Provider NPI: _____ Specialty: _____
Address: _____ City/ST/Zip: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Test/Lab Results for Asthma diagnosis (required)

- | | |
|---|--|
| <input type="checkbox"/> Pre-treatment serum eosinophil level (for IL-5 drugs) | <input type="checkbox"/> Pre-treatment IgE level (for Xolair) |
| <input type="checkbox"/> Pre-treatment Pulmonary function test (FEV-1 <80% predicted) | <input type="checkbox"/> Positive skin or RAST test to a perennial aeroallergen (for Xolair) |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Test/Lab Results for Urticaria diagnosis (required)

- Baseline Urticaria Activity Score Other: _____

Test/Lab Results for Food Allergy diagnosis (required)

- Pre-treatment IgE level Oral food challenge
 Positive skin prick or RAST test to a food allergen Other: _____

Prior Failed Therapies

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____