Asthma Therapies

Please fax completed referral form to 972-473-7563

PATIENT DEMOGRAPHIC INFORMATION

Patient's name:_____ Date of birth: _____Phone #: _____

Address:_____ City/State/Zip: _____

Allergies:_____ Weight:_____ Height: _____

DIAGNOSIS & CLINICAL INFORMATION

Diagnosis: *(ICD 10 Code Required)*

☐ Moderate Asthma (J45.40-J45.42), ICD 10_____ ☐ Severe Asthma (J45.50-J45.52), ICD 10_____

☐ Unspecified Asthma (J45.901-J45.909), ICD 10_____ ☐ Other: _____

Prior Failed Therapy:

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Test Results: Please attach copy for all items checked.

☐ IgE level
☐ Skin test or RAST test
☐ Eosinophil count
☐ Pulmonary function test pre- and post-bronchodilator
☐ Other: _____

Please include copy of insurance card, most recent H&P or MD note, medication list, and lab results.

THERAPY ORDERED

MEDICATION	DOSE	DIRECTIONS/DURATION
Xolair® (omalizumab)	_____mg	☐ Inject SUBQ every _____weeks x 1 year ☐ Calculate dose and frequency per patient weight and IgE level
Nucala® (mepolizumab)	100mg	☐ Inject SUBQ every 4 weeks x 1 year
Cinqair® (reslizumab)	_____mg (3mg/kg)	☐ Infuse IV every 4 weeks x 1 year
Fasenra™ (benralizumab)	30mg	☐ **INITIAL:** Inject SUBQ every 4 weeks x 3 doses ☐ **MAINTENANCE:** Inject SUBQ every 8 weeks x 1 year
OTHER:		
OTHER:		
OTHER:		

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES** If yes, Facility Name: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Office Contact: _____ Phone #: _____ Fax #: _____

AIR Care
Allergy, Immunology & Respiratory Care

AIR Care | 3600 Communications Parkway | Plano, TX 75093
Phone 972.473.7544 | Fax 972.473.7563

Revised 5/7/2018