BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

ALLERGY / IMMUNOLOGY INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Patient Weight: _____ lbs. (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** 600mg Sub-Q **Xolair frequency**: ☐ Every 2 weeks ☐ Every 4 weeks	☐ _____ ☐ x 1 year
☐ Severe Asthma with Eosinophilic phenotype (ICD-10 Code:_____) ☐ Severe Granulomatosis with Polyangiitis (ICD-10 Code:_____)	☐ **Cinqair** 3mg/kg IV every 4 weeks ☐ **Fasenra** initial dose: 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30 mg Sub-Q every 8 weeks thereafter ☐ **Fasenra** 30mg Sub-Q every 8 weeks ☐ **Nucala** 100mg Sub-Q every 4 weeks ☐ **Nucala** 300mg Sub-Q every 4 weeks ☐ **Tezspire** 210mg Sub-Q every 4 weeks	☐ _____ ☐ x 1 year
☐ Common Variable Immunodeficiency (ICD-10 Code:_____) ☐ Other: _____ (ICD-10 Code:_____)	**Immunoglobulin**: ☐ **IV** ☐ **SubQ** _____ mg/kg **OR** _____ gm/kg x ____ day(s) **OR** divided over ____ day(s) **Frequency**: Every _____ weeks OR _____ (*Biocare Infusion to choose if not indicated*) Brand: _____ Additional Ig orders: _____	☐ _____ ☐ x 1 year

Premedication orders Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Quzyttir 10mg IVP
Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP
☐ Other _____

Lab orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____
Required labs to be drawn by: ☐ Biocare Infusion ☐ Referring provider

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

COMPREHENSIVE SUPPORT FOR ALLERGY / IMMUNOLOGY THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Please indicate any tried and failed therapies (if applicable):
    - ☐ Corticosteroids _____
    - ☐ Long acting beta 2 agonist _____
    - ☐ Long acting muscarinic antagonist _____
    - ☐ Immunosuppressants (EGPA) _____
  - ☐ *Asthma* - Does the patient have a history of 2 exacerbations requiring a course of oral/ systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? ☐ Yes ☐ No
  - ☐ *Asthma* - Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? ☐ Yes ☐ No
  - ☐ *PI* - Documentation of recurrent bacterial infections, history of failure to respond to antibiotics , documentation of pre and post pneumonococcal vaccine titers
- ☐ Include labs and/or test results to support diagnosis **(attach results)**
- ☐ Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks (*asthma & EGPA*) or ≥ 1000 cells/mcL within 4 weeks (*HES*)? ☐ Yes ☐ No
- ☐ FEV1 score (if applicable): _____
- ☐ Serum IgE level - *for asthma & nasal polyps Xolair*
- ☐ Skin/RAST test - *for asthma Xolair*
- ☐ Serum immunoglobulins - *for Ig*
- ☐ Serum creatinine - *for Ig*
- ☐ CBC w/differential - *for Fasenra, Nucala, Cinqair*
- ☐ If injection order, is the patient or caregiver not competent or physically unable to administer the product for self-administration? ☐ Yes ☐ No
- ☐ Xolair - Patient has Epi pen prescribed
- ☐ Other medical necessity: _____

Biocare Infusion 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 refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance