

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
<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 <input type="checkbox"/> Xolair 600mg Sub-Q Xolair frequency: <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
<input type="checkbox"/> Severe Asthma with Eosinophilic phenotype (ICD-10 Code: _____) <input type="checkbox"/> Severe Granulomatosis with Polyangiitis (ICD-10 Code: _____)	<input type="checkbox"/> Cinqair 3mg/kg IV every 4 week <input type="checkbox"/> Dupixent initial dose: 600mg (2 syringes) Sub-Q at different injection sites, After two weeks, 300mg (1 syringe) Sub-Q every OTHER week. <input type="checkbox"/> Fasenra initial dose: 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30 mg Sub-Q every 8 weeks thereafter <input type="checkbox"/> Fasenra 30mg Sub-Q every 8 weeks <input type="checkbox"/> Nucala 100mg Sub-Q every 4 weeks <input type="checkbox"/> Nucala 300mg Sub-Q every 4 week <input type="checkbox"/> Tezspire 210mg Sub-Q every 4 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
<input type="checkbox"/> Alpha-1 Antitrypsin Deficiency (ICD-10: 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

Lab orders: _____ **Lab Frequency:** _____

 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:



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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 antibiotic, documentation of pre and post pneumococcal 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 IgA - for *Prolastin, Glassia (contraindicated in IgA deficiency)*
- Alpha1-antitrypsin (AAT) level - for *Prolastin, Glassia*
- CBC w/differential - for *Fasenra, Nucala, Cinqair*
- Injection order - Is the patient or caregiver competent for self-administration? Yes No
Is the patient physically able 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