SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

ASTHMA AGENTS

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

PRESCRIPTION ORDERS

a) WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY 10 %
b) Pretreatment Serum IgE (Xolair) _____

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	XOLAIR	☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg	SQ	Every _____ days	
☐	FASENRA (LOADING DOSES)	30 mg	SQ	Every 4 weeks for 3 doses, then every 8 weeks	
☐	FASENRA (MAINTENANCE DOSES)	30 mg	SQ	Every 8 weeks	
☐	NUCALA	100 MG	SQ	Every 4 weeks	
☐	TEZSPIRE	210 mg	SQ	Every 4 weeks	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
☐	NONE	NA	NA
☐	BENADRYL		
☐	ACETAMINOPHEN		
☐	OXYGEN		
☐	Other:		
☐	Other:		
☐	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
☐	NONE	NA	NA
☐	BMP	☐ PRIOR ☐ POST	
☐	CMP	☐ PRIOR ☐ POST	
☐	BUN/CREATININE	☐ PRIOR ☐ POST	
☐	CRP:	☐ PRIOR ☐ POST	
☐	ESR:	☐ PRIOR ☐ POST	
☐	Other:	☐ PRIOR ☐ POST	

NOTES/SPECIAL INSTRUCTIONS:

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.