

Physician Infusions Fasenra Referral Form

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____
Address: _____ Phone: _____ Email: _____

Insurance Information (Include a copy of the front and back of patient's insurance card)

Primary: _____ Policy #: _____ Group #: _____ Ins Phone: _____
Secondary: _____ Policy #: _____ Group #: _____ Ins Phone: _____

Referring Provider Office Information

Provider Name: _____ NPI: _____ Office Name: _____
Office Address: _____
Office Contact: _____ Phone: _____ Fax: _____ Email: _____

Pre-medications

☐ Physician Infusions to order pre-medications per standard infusion protocols/procedures

-- OR --

☐ _____ mg Acetaminophen PO	☐ _____ mg Diphenhydramine PO
☐ _____ mg Cetirizine PO	☐ _____ mg Diphenhydramine IV
☐ _____ Other IV/PO	☐ _____ mg Solumedrol IV

Required Labs

☐ Physician Infusions to order baseline labs/screenings per standard infusion protocols/procedures

-- OR --

☐ CBC, CMP, Quantiferon TB

Laboratory Frequency: _____

Prescription

Diagnosis Code: _____ **Diagnosis Description:** _____

Allergies:

Medication: Fasenra Route: Subcutaneous injection First Injection? Y/N Last InjectionDate (If applicable): _____

Dose: 30 mg Refills: _____ How many injections has the patient had?: _____

Frequency:

☐ Every 8 weeks

-- OR --

☐ Every 4 weeks for 3 injections, then every 8 weeks

Is the patient required to stay for a 30-minute observation period? Y/N

☒ Provide nursing care per Physician Infusions policies and procedures, including but not limited to post-infusion observation and management of adverse reactions.

Special Instructions

Please send completed referral form, office notes, labs/imaging results (including TB result and date if applicable) to Physician Infusions fax (512) 354-4938.

Prescriber Signature: _____ Prescriber Printed Name: _____ Date: _____