

Pulmonology & Allergy Order Form

Specialty-specific infusion order form for pulmonology & allergy

REFERRING PROVIDER

PROVIDER NAME NPI DEA (IF CONTROLLED) SPECIALTY

PRACTICE / CLINIC NAME OFFICE PHONE OFFICE FAX

OFFICE CONTACT NAME CONTACT PHONE CONTACT EMAIL

PATIENT INFORMATION

PATIENT LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH SEX PATIENT PHONE BEST TIME TO CONTACT

ADDRESS CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE MEMBER ID GROUP #

SECONDARY INSURANCE (IF ANY) MEMBER ID GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE) ICD-10 CODE

Common indications for this medication: Severe eosinophilic asthma (J45.5x), CRSwNP (J33.x), hereditary angioedema (D84.1)

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME
PULMONOLOGY & ALLERGY MEDICATIONS &MDASH; COMMONLY ORDERED

Fasenra (benralizumab), Nucala (mepolizumab), Xolair (omalizumab), Tezspire (tezepelumab), Cinqair (reslizumab)

MEDICATION ORDER

MEDICATION	GENERIC / ALT	STRENGTH / FORMULATION
DOSE	FREQUENCY	DURATION
ROUTE	PRE-MEDICATIONS (IF ANY)	SPECIAL INSTRUCTIONS
ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)
		BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Ascribe to verify before each infusion:

- | | | |
|--|--|---|
| ☐ CBC w/ differential | ☐ CMP | ☐ Liver function panel |
| ☐ Hepatitis B/C panel | ☐ TB screen (T-SPOT or QFT) | ☐ Pregnancy test (urine) |
| ☐ Iron studies (ferritin, TSAT) | ☐ Vitamin levels (B12, D, folate) | ☐ Other (specify below) |

OTHER LABS / MONITORING REQUIREMENTS
PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Ascribe Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE	PRINTED NAME	DATE
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Form code: ARB-ORDER-PULMONOLOGY · Submit to Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com