Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to pharmacy.

Asthma & Allergy

Referral for Medication and Patient Management Program

OptiMed
6480 Technology Ave., Suite A | Kalamazoo, MI 49009
Phone: 877.385.0535
Fax: 877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

Patient Demographics

Name _____ Sex ☐M ☐F
DOB _____ SSN _____
Phone _____ 2nd Phone _____
Address _____ Apt/Suite _____
City, State, ZIP _____
Primary language, if other than English _____

Provider Information

Prescriber _____
NPI _____ DEA _____
Practice Name _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____ Key contact _____

This is a ☐ New Rx ☐ Refill
Training by ☐ Prescriber's office ☐ Not needed ☐ Pharmacy to facilitate
Ship to / Site of Care ☐ Prescriber's office ☐ Patient ☐ OptiMed Infusion Center ☐ Other _____

Clinical Information

Diagnosis
☐ L20.9 Atopic dermatitis, unspecified
☐ L20.8___ Other atopic dermatitis _____
☐ L50.1 Idiopathic urticaria
☐ J82.___ Eosinophilic Asthma _____
☐ Other (include ICD-10) _____

Weight _____ ☐ lb ☐ kg **Height** _____ ☐ in
Allergies _____ **Latex allergy?** ☐Yes ☐No
Prior treatments & reason for discontinuation _____
_____
Other notes _____

If ordering any of the following: **Cinqair®**, **Fasenra™**, **Nucala®**, **Xolair®**:
Will this be the patient's first dose? ☐Yes ☐No, date of last dose: _____ Previous treatment history and response: _____
History of parasitic infection? ☐Yes ☐No _____
Patient history of anaphylactic-type reaction(s)? ☐Yes ☐No If Yes, please describe _____
For XOLAIR/asthma patients -- Positive skin test or in-vitro reactivity to perennial aeroallergen? ☐Yes ☐No **Pre-treatment IgE** _____ IU/mL **Date** _____
For NUCALA: Has the patient previously received the shingles vaccines? ☐Yes ☐No *(consider vaccination if medically appropriate)*

Medication	Directions	Quantity	Refills
☐ **Cinqair®** 100mg vial(s) (reslizumab) ^	Infuse 3mg/kg in 50mL NaCL 0.9% IV over 20 to 50 minutes every 4 weeks. **Supplies:** ☐ No supplies needed, we have on hand ☐ OptiMed to supply Quantity Sufficient for each dose ordered of the following: One-50mL IV bag of 0.9% Sodium Chloride Injection; Luer Lock syringe and needle; One infusion set with 0.2 micron filter *^Administration by a healthcare professional only per labeling.*	1 dose	_____
☐ **Dupixent®** 300mg (dupilumab)	☐ **Initial:** Inject 600mg (2 syringes) SQ at different injection sites on day 1. ☐ **Maintenance:** Beginning day 15, inject 300mg SQ every OTHER week.	2 syringes 2 syringes	Zero _____
☐ **Fasenra™** 30mg (benralizumab) ^	☐ **Initial:** Administer 30mg SQ at week 0, week 4, and week 8. ☐ **Maintenance:** Beginning week 16, administer 30mg SQ once every 8 weeks. *^Administration by a healthcare professional only. per labeling.*	1 syringe 1 syringe	2 refills _____
☐ **Nucala®** 100mg (mepolizumab)	☐ **Severe Asthma:** Administer 100mg SQ once every 4 weeks. ☐ **Eosinophilic granulomatosis with polyangiitis:** Administer 300mg (3 injections) SQ once every 4 weeks. **Supplies:** ☐ No supplies needed, we have on hand ☐ No supplies needed (for prefilled syringes or pens) ☐ OptiMed to supply Quantity Sufficient for each dose ordered of the following: Sterile Water for Injection, Luer Lock syringe(s) and needle(s) for reconstitution & SQ injection ‡ ☐ *As the prescriber I have confirmed that self-injection by the patient or caregiver is appropriate for this patient (check if ordering for home use and deemed appropriate).*	4-week supply of ☐ pen(s) ‡ ☐ syringe(s) ‡ ☐ vial(s) for reconstitution* (admin. by HCP only)	_____
☐ **Xolair®** 75mg ☐ **Xolair®** 150mg (omalizumab) ^	**Dosing:** Administer ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg per dose SQ* ... **Frequency:** ... every ☐ 2 weeks ☐ 4 weeks *Maximum dose of 150mg administered per injection site. **Supplies:** ☐ No supplies needed, we have on hand ☐ No supplies needed (for prefilled syringes) ☐ OptiMed to supply Quantity Sufficient for each dose ordered of the following: Sterile Water for Injection, Luer Lock syringe(s) and needle(s) for reconstitution & SQ injection *^Administration by a healthcare professional only per labeling.*	4-week supply of ☐ syringes ☐ vials for reconstitution	_____

Epinephrine orders: All patients receiving **Nucala®** or **Xolair®** must have orders for epinephrine (regardless of indication)

☐ **AUVI-Q®** ☐ **EpiPen®** or **EpiPen Jr®** ☐ **Symjepi™**	**Select weight/dose:** ☐ ≥ 30kg: 0.3mg ☐ 15 to 30kg: 0.15mg Inject one injector into outer thigh IM for allergic reaction. Call 911. Patient to bring epinephrine devices to all appointments and always have available following the administration of each dose of (Nucala®, Xolair®)	☐ 1 carton (2 injectors) ☐ 2 cartons (4 injectors)	_____

^ Administration by a healthcare professional only. Ship to Provider Office or administer at OptiMed Ambulatory Infusion Center as indicated above.

Provider Signature _____ **Date** _____

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

V121919A

CLEAR FORM