COMPASSUS®

ALLERGY / IMMUNOLOGY INFUSION ORDERS

P: 888-386-0886 | F: 586-263-3306

PATIENT INFORMATION:

Fax completed form, insurance information and clinical documentation to 586-263-3306

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ❒ New to Therapy ❒ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION:

Patient weight: _____ lbs. Allergies: _____

THERAPY ORDER

Diagnosis	Infusion Orders	Refills
❒ Common Variable Immunodeficiency (ICD-10 Code: ___) ❒ Other: _____ (ICD-10 Code: _____)	**Immunoglobullin:** ❒ **IV** ❒ **SubQ** _____ mg/kg **OR** ___ gm/kg x _____ day(s) OR divided over ___ day(s) **Frequency:** Every_____ weeks OR_____ (Compassus to choose if not indicated) Brand: _____ Additional lg orders: _____	❒ _____ ❒ x 1 year

Premedication orders: **Tylenol** ❒ 1000mg ❒ 500mg PO, please choose one antihistamine:
❒ Diphenhydramine 25 mg PO ❒ Loratadine 10mg PO ❒ Cetirizine 10mg ❒ Quzyttir 10mg IVP

Additional premedications: ❒ Solu-Medrol _____ mg IVP ❒ Solu-Cortef _____ mg IVP
❒ Other: _____

Lab orders: _____ **Frequency:** ❒ Every infusion ❒ Other: _____

Required labs to be drawn by: ❒ Compassus ❒ Referring Provider

PROVIDER INFORMATION:

By signing this form and utilizing our services, you are authorizing *Compassus* 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.

Patient Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

❒ Opt out of Compassus selecting site of care (if checked, please list site of care): _____

PREFERRED LOCATION:

City: _____ State: _____

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Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND 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 with a 12-month period? ❒ Yes ❒ No
- ❒ ***Asthma*** - Does the patient have a ACQ score consistently greater than 1.5 or ACT sore consistently less than 120 ❒ Yes ❒ No
- ❒ ***PI***- Documentation of recurrent bacterial infections, history of failure to respond to antibiotics, documentation of pre and post pneumococcal vaccine titer. Failure to respond to two vaccines or pneumococcal vaccine.

❒ 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 cellsmcL 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 immunoglobulins - ***for Ig***
- ❒ Serum creatinine - ***for Ig***
- ❒ CBC w/ differeential - ***for Fasenra, Nucala, Cinqair***

❒ If injection order, is the patient or caregiver not competent or physically unable to administer the ***product for self-administration?*** ❒ Yes ❒ No

❒ Xolair - Patient has Epi pen prescribed

Compassus will complete insurance verification and submit all the required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if an 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.