CureStat Rx
Home Infusion and Specialty Pharmacy

ALLERGY/IMMUNOLOGY REFERRAL FORM

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City_____ State_____ Zip: _____
Primary Phone: _____ SSN: _____
Caregiver Name: _____
Alternate Phone: _____

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Address: _____
City_____ State_____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Please fax a copy of front and back of the insurance card(s).

Clinical Information

Diagnosis: ☐ J45.40 Moderate Asthma ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with acute exacerbation
☐ Other: ICD 10 code and description _____
Allergies: ☐ NKDA ☐ Other: _____ Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in
Concomitant therapies: ☐ Short-acting beta agonist ☐ Long-acting beta agonist ☐ Antihistamines ☐ Decongestants ☐ Immunotherapy
☐ Inhaled corticosteroids ☐ Leukotriene modifiers ☐ Oral steroids ☐ Nasal steroids ☐ Other: _____
Lab results: ☐ History of positive skin or RAST test to perennial aeroallergen
☐ Pretreatment IgE level: _____IU/mL ☐ Eosinophil Count: _____ ☐ Test Date: _____
Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continued therapy Date of last injection: _____

Drug	Dose/Strength	Directions	Qty	Refills
☐ **FASENRA** (benralizumab)	☐ 30 mg/mL Prefilled Syringe ☐ 30 mg/mL Auto-Injector	☐ Loading Dose: Inject 30mg every 4 weeks for 3 doses ☐ Maintenance Dose: Inject 30mg every 8 weeks		
☐ **CINQAIR** (Reslizumab)	☐ 100mg/10mL single use vial	☐ Infuse 3mg/kg once every 4 weeks over 20-50mins		
☐ **DUPIXENT** (dupilumab)	☐ 300 mg/2 mL prefilled syringe ☐ 200 mg/1.14 mL prefilled syringe	☐ Loading dose: Inject 600mg SC at week 0 ☐ Maintenance dose: Inject 300mg SC every other week ☐ Loading dose: Inject 400mg SC on Day 1 ☐ Maintenance dose: Inject 200mg SC every other week		
☐ **NUCALA** (mepolizumab)	☐ 100mg vial ☐ 100mg/mL Prefilled syringe	☐ Inject 100mg SC once every 4 weeks ☐ Inject 300mg SC once every 4 weeks		
☐ **XOLAIR** (omalizumab)	☐ 75mg/0.5mL Prefilled syringe ☐ 150mg/mL Prefilled syringe ☐ 150mg vial	☐ Inject _____mg SC every _____ weeks		

Injection training provided by: ☐ Prescriber's office ☐ Pharmacy ☐ Other: _____

Prescriber's Signature: _____ Date: _____