



PYRAMIDS INFUSION SERVICES

CONTACT US:

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Allergy/Immunology Enrollment Form

PATIENT INFORMATION -

Patient Name: _____ DOB: _____ Phone: _____

Patient Weight: _____ lbs. (required) Address: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Next Treatment Date: _____

DIAGNOSIS

- ☐ Persistent Asthma ☐ Nasal Polyps ☐ Severe Granulomatosis w/ Polyangiitis
☐ Chronic Idiopathic Urticaria ☐ Severe Asthma ☐ Common Variable Immunodeficiency
☐ Other: _____

ICD-10 Code: _____

THERAPY ORDER

MEDICATION	ORDERS	REFILL	PRE-MEDICATIONS	LAB ORDERS
Immunoglobulin: ☐ IV ☐ SubQ	Orders: _____ mg/kg OR _____ gm/kg OR divided over _____ day(s) Preferred Brand*: _____ *If left blank, clinicians to determine medication	Frequency: Every _____ weeks OR _____	☐ Acetaminophen ☐ 500mg PO Please choose one antihistamine: ☐ Diphenhydramine ☐ 25mg PO ☐ 50mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO Additional Pre-medications: ☐ Solu-Medrol _____mg IVP ☐ Other: _____	☐ FEV1 Score, if applicable _____ ☐ Serum IgE Level ➤ Xolair, Asthma ➤ Xolair, Nasal Polyps ☐ Skin/ RAST Test ➤ Xolair, Asthma ☐ Serum Immunoglobulins ➤ Immunoglobulin ☐ Serum Creatinine ➤ Immunoglobulin ☐ CBC w/ differential ➤ Cinqair ➤ Fasenra ➤ Nucala
☐ Cinqair	☐ 3mg/kg IV every 4 weeks	☐ _____		
☐ Fasenra	Initial Dose: ☐ 30mg SubQ every 4 weeks for the first 3 doses Maintenance: ☐ 30mg SubQ every 8 weeks	☐ x1 year		
☐ Nucala	☐ 100mg SubQ every 4 weeks ☐ 300mg SubQ every 4 weeks			
☐ Tezspire	☐ 210mg SubQ every 4 weeks			
☐ Xolair	☐ 75mg SubQ ☐ 375mg SubQ Frequency: ☐ 150mg SubQ ☐ 450mg SubQ ☐ Every 2 weeks ☐ 225mg SubQ ☐ 525mg SubQ ☐ Every 4 weeks ☐ 300mg SubQ ☐ 600mg SubQ			

☐ Please indicate any tried and failed therapies, if applicable

- ☐ Corticosteroids _____
☐ Long acting beta 2 agonist _____
☐ Long acting muscarinic antagonist _____
☐ Immunosuppressants (EGPA) _____

☐ Does the patient have a history of 2 exacerbations requiring a course of oral/ systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? Asthma Diagnosis
☐ Yes ☐ No

☐ Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently ranging between 5-25? Asthma Diagnosis
☐ Yes ☐ No

☐ Documentation of recurrent bacterial infections, history of failure to respond to antibiotics, documentation of pre and post pneumococcal vaccine titers P/I

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

☐ Patient has Epi-Pen prescribed, Xolair

☐ Other medication documentation: _____

PROVIDER INFORMATION

Provider Name: _____ Date: _____

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

PRESCRIBER SIGNATURE

Prescriber's Signature: _____

Date: _____

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