Date Shipment Needed: _____ Ship To: ☐Patient ☐Prescriber
☐ Nursing needed; ☐Training needed ► All the supplies including syringes and needles will be dispensed if needed.

O-Z ASTHMA REFERRAL FORM

Phone: 800.511.5144 • Fax: 877.541.1503

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ☐M ☐F	Weight:	☐lbs. ☐kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Please attach demographic information**		

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

☐J82 Pulmonary Eosinophilia ☐J45.40 Moderate Persistent Asthma, uncomplicated ☐J45.50 Severe Persistent Asthma, uncomplicated ☐Other ICD10 _____

FEV1: _____% Pre-treatment serum IgE: ☐<30 IU/mL ☐≥30-100 IU/mL ☐>100-200 IU/mL ☐>200-300 IU/mL ☐>300-400 IU/mL ☐>400-500 IU/mL ☐>500-600 IU/mL ☐>600-700 IU/mL

Patient's medical history includes: ☐Positive RAST ☐Positive skin test to perennial aeroallergen ☐Asthma with eosinophilic phenotype ☐Other _____

Current maintenance treatment (include dose and frequency):_____

Current exacerbation treatment (include dose and frequency):_____ Patient is a smoker or is exposed to smoke in the home: ☐ Yes ☐No

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card**	**Copay ID:**

PRESCRIPTION INFORMATION

☐**STC Standard Protocol** will include the following: (1) dispensing ordered med/dose, (2)diluent mix and / or dilute dose. (3) Normal Saline flushes and extra Normal Saline 10ml to flush line and anakit med(epinephrine 0.3mg IM/0.15mg IM (for pediatric patients) and diphenhydramine 50mg/mL) prn.

☐**Tezspire (Tezepelumab-ekko)**
☐ 210mg Pen ☐ 210mg PFS
Inject 210mg SQ once every 4 weeks
QTY: 1 month Refills:____

☐ **Xolair® (Omalizumab**) 75mg and/or 150mg ☐ Vial ☐ Pre-filled Syringe
☐ 225 mg SQ every 2 weeks
☐ 300 mg SQ every 2 weeks
☐ 375 mg SQ every 2 weeks
_____ mg SQ every 2 weeks
☐ 75 mg SQ every 4 weeks
☐ 150 mg SQ every 4 weeks
☐ 225 mg SQ every 4 weeks
☐ 300 mg SQ every 4 weeks
☐ 375 mg SQ every 4 weeks
_____ mg SQ every 4 weeks
QTY: 1 month Refills:____

☐ Diluent (sterile water) 10 mL Vial – Use to reconstitute medication
QTY: 1 month Refills:____
☐ Syringe 18 g 1 inch (to mix) ☐ Needle 25 g (to inj.)
QTY: 1 month Refills:____

I authorize AcariaHealth to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at any time in writing by sending a letter to AcariaHealth 6923 Lee Vista Blvd, Suite 300 Orlando, FL 32822. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. A copy of this authorization will be utilized with the same effectiveness as the original

Patient Signature *(required for participation)* _____ Date _____

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.