Pulmonology
Referral Form

Please fax completed form to:

Fax: 386-385-7871
Phone 386-456-3000
AccordSpecialty@gmail.com

Ship To/Site of Care:	☐ In Office	☐ At Home	☐ Other (list):

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescriber Name:			
Address:				Address:			
City, State, Zip:				City, State, Zip:			
Phone:		Weight (kg)		NPI AND License:			
Alt Phone:		Gender:		Office Contact:		Email:	
DOB:		SSN:		Px:		Fax:	

CLINICAL INFORMATION

Allergies:	☐ NKDA	☐ Allergies:				
Diagnosis:	ICD-10:		Condition:		Date of Diagnosis:	

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
☐ **Cinqair**	100 mg/10 mL	☐ Infuse 3 mg/kg IV over 20-50 minutes every 4 weeks		
☐ **Fasenra**	☐ 30 mg/mL Pen ☐ 30 mg/mL PFS	☐ INITIAL: Inject 30 mg SC every 4 weeks x 3 doses. ☐ MAINT: Inject 30 mg SC every 8 weeks.		0
☐ **Nucala**	☐ 100 mg/mL Pen ☐ 100 mg/mL PFS	☐ Inject 100 mg SC every 4 weeks.		
☐ **Rituximab** (Riabni, Rituxan, Ruxience, Truxima)	☐ 100 mg/10 mL ☐ 500 mg/50 mL ☐ Choice of brand per payer preference	☐ INITIAL: Infuse 1 g IV at weeks 0, 2. ☐ Infuse _____ mg IV every _____ for _____ doses ☐ Do not auto-substitute. Brand Preferred: _____		0
☐ **Tezspire**	☐ 210 mg Pen ☐ 210 mg PFS	☐ Inject 210 mg SC once every 4 weeks.		
☐ **Xolair**	☐ 150 mg/mL ☐ 300 mg/2mL Circle: Pen PFS	☐ Inject _____ mg SC every _____ weeks		
☐ **Other (list)**				

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

PRESCRIBER SIGNATURE

By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Accord Specialty to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed. I understand that I can revoke this designation by providing notice to Accord.

Prescriber's Signature: _____ Date: _____