

# COPD REFERRAL FORM



FAX REFERRAL TO: +1(844) 277-0049

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## 1 PATIENTS INFORMATION (Complete or include demographic sheet)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  MALE  FEMALE  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_ SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## 2 INSURANCE (Please attach if Available a copy of the Patients' insurance card(s) Front/ Back)

Primary Insurance: \_\_\_\_\_ Policy No: \_\_\_\_\_ Group: \_\_\_\_\_  
 Primary RX Insurance: \_\_\_\_\_ ID No: \_\_\_\_\_ RX GRP: \_\_\_\_\_ RX BIN: \_\_\_\_\_ RX PCN: \_\_\_\_\_

## 3 DIAGNOSIS AND CLINICAL INFORMATION

### Diagnosis (ICD-10) and Patient Clinical Information:

ICD-10 Diagnosis Code(s): \_\_\_\_\_ (COPD ICD-10 Codes generally range from J41-J44.9. Other codes may apply.)  
 Drug Allergies: \_\_\_\_\_  NKDA Ht: \_\_\_\_\_ in/cm Wt: \_\_\_\_\_ lbs/Kg  
 Current maintenance COPD medications: \_\_\_\_\_  
 Tried and failed maintenance COPD medications: \_\_\_\_\_

## 4 PRESCRIPTION INFORMATION

ACCESS:  SUBCUTANEOUS

MEDICATION	STRENGTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Dupixent <i>(dupilumab)</i>	300mg/2 mL	Inject 300 mg SC every 2 weeks	Q.S	(x1) Year
<input type="checkbox"/> Nucala <i>(mepolizumab)</i>	<b>Vial</b> <input type="checkbox"/> 100 mg vial <b>PEN</b> <input type="checkbox"/> 100 mg/mL auto-injector <b>PFS</b> <input type="checkbox"/> 100 mg/mL PFS <input type="checkbox"/> 40 mg/0.4 mL PFS	<b>Severe Asthma:</b> <input type="checkbox"/> Adults & Adolescents 12 years and older: Inject 100 mg SC once every 4 weeks. <input type="checkbox"/> Pediatric (6-11 years old): Inject 40 mg SC once every 4 weeks. <b>Chronic Obstructive Pulmonary Disease (COPD):</b> <input type="checkbox"/> Inject 100 mg SC once every 4 weeks. <b>Eosinophilic Granulomatosis with Polyangiitis (EGPA)</b> <input type="checkbox"/> Inject 300 mg as (3 separate) 100 mg SC injections once every 4. <b>Hypereosinophilic Syndrome (HES)</b> <input type="checkbox"/> Inject 300 mg as (3 separate) 100 mg SC injections once every 4 weeks	Q.S	(x1) Year

### ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input type="checkbox"/> EPINEPHRINE (autoinjector)	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 0.1 mg (Wt 7.5-15 kg)	Quantity: (x2) Pen(s)	Refills: PRN

### NURSING/ LABS/ INFUSION SUPPLIES:

- NURSING: Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.  
 INFUSION SUPPLIES: Infusion supplies and infusion pump PRN for the administration and disposal of medication.

## 5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: \_\_\_\_\_ Title:  MD  DO  ND  PA  APRN NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/ State/ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

DISPENSE AS WRITTEN  BRAND MEDICALLY NECESSARY  DO NOT SUBSTITUTE  May Substitute /  Product Selection Permitted /  Substitution Permissible  
 NO SUBSTITUTION /  DAW /  MAY NOT SUBSTITUTE

PRESCRIBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

**Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.**

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

**CONFIDENTIALITY NOTICE:** The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to [info@ivsolutionsrx.com](mailto:info@ivsolutionsrx.com) and destroy all copies of the original message.