echocare
SPECIALTY PHARMACY
"Your partner in patient care"

260 Broadway
Brooklyn, NY 11211
Phone: 718-782-0101
Fax: 718-782-2626
www.EchoDrugs.net

RESPIRATORY DISORDERS REFERRAL FORM

Fax prescription to: 718-782-2626

Faxed prescriptions can only be accepted from prescribing practitioners

Date Needed By _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ SS# _____ DOB _____

☐ Male ☐ Female Height_____ Weight _____ Age _____

Allergies _____ ☐ NKDA

INSURANCE INFORMATION

Please attach front and back of all insurance and prescription drug cards

PRESCRIBER INFORMATION

Name _____

NPI _____ State License# _____

Group/Hospital _____

Address _____

City, State, Zip _____

Main Phone _____ Fax _____

Contact Person _____ Phone _____

CLINICAL EVALUATION

DIAGNOSIS

☐ Moderate persistent asthma, uncomplicated (J45.40)
☐ Severe persistent asthma, uncomplicated (J45.50)
☐ Idiopathic urticaria (L50.1)

☐ Other _____

ICD-10 Code _____ Diagnosis Date _____

Please include a copy of lab reports, clinical data, and current vital signs. Fax to: 718-782-2626

PATIENT HAS: (check all that apply)

☐ Chronic Idiopathic Urticaria
☐ Allergic Asthma
☐ Moderate to severe allergic persistent asthma
☐ History of positive skin or RAST test to a perennial aeroallergen

PREVIOUS MEDICATIONS/THERAPIES

Medication/Therapy	Date/Duration/Reason for discontinuation

CONCOMITANT THERAPIES

☐ Short acting beta agonist
☐ Long acting beta agonist
☐ Combination Therapy (LAB/ICS)
☐ Leukotriene Modifier
☐ Immunotherapy
☐ H1 antihistamines
☐ Inhaled Corticosteroid
☐ Theophylline
☐ Oral steroids
☐ Other: _____

ER visits/Hospitilazation dates _____

Unscheduled office visit dates _____

Pretreatment serum IgE Level IU/ml *(1.0 kU/L=1.0 IU/ml; 2.4 ng/ml=1.0 IU/ml)* _____

LgE Level _____ **Date of Test** _____ **Weight** _____**kg/lbs Weight Date** _____

Clinical impression:

PRESCRIPTION INFORMATION

☐ **XOLAIR (omalizumab)**

PATIENT TYPE

☐ Naive/New Start
☐ Continued Treatment
☐ Restart
☐ Last Injection Date _____

APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA

Quantity: ☐ 30-Day supply ☐ 90-Day supply

☐ Diluent: 10ml vial pf sterile water for injection, USP; ancillary supply; 3-ml syringes & 18-gauge needles as needed for reconstitution; 25-gauge needles as needed for adminsitration

☐ 150 mg/dose every 4 weeks
☐ 225 mg/dose every 2 weeks
☐ 375 mg/dose every 2 weeks
☐ 300 mg/dose every 2 weeks
☐ 300 mg/dose every 4 weeks
☐ Refills: _____

APPROPRIATE PATIENTS WITH CIU

Quantity: ☐ 30-Day supply ☐ 90-Day supply

☐ Diluent: 10ml vial pf sterile water for injection, USP; ancillary supply; 3-ml syringes & 18-gauge needles as needed for adminsitration

☐ 150 mg/dose every 4 weeks
☐ 300 mg/dose every 4 weeks
☐ Refills: _____

MEDICATION	STRENGTH/DOSAGE	DIRECTIONS	QUANTITY	REFILLS
☐ **PERFOROMIST (formoterol fumarate)**	☐ 20 mcg/2 ml solution *(for oral inhalation only)*	☐ One 20 mcg/2 ml vial every 12 hours *(use standard jet nebulizer with facemask or mouthpiece connected to an air compressor)*		
☐ **OTHER** _____				
☐ **OTHER** _____				
☐ **OTHER** _____				
☐ **OTHER** _____				
☐ **OTHER** _____				

By signing this form and utilizing our services, you are authorizing Echo Care Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature _____ ☐ DAW Date _____