Allergy/Immunology Referral Form	Y Medical Associates Fax Referral To: 855-838-0623 Phone: 800-447-7558	YMedical ASSOCIATES
Date: _____		

Patient Information

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

DOB: _____

Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

DEA: _____ NPI #: _____

Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____

Secondary Insurance: _____ ID#: _____ Group: _____

Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Clinical Information (please fax all pertinent clinical information)

Diagnosis: ☐ J45 (Asthma) ☐ J45.50 (Severe Asthma) ☐ L50 (Urticaria) ☐ L20 (Atopic Dermatitis) ☐ K20.0 (Eosinophilic Esophagitis) ☐ L28.1 (Prurigo Nodularis) ☐ J44 (Chronic Obstructive Pulmonary Disease) ☐ M30.1 (EGPA) ☐ D72.11 (HES) ☐ ICD-10 _____ (Diagnosis): _____

Diagnosis Date: _____ Height: _____ Weight: _____

Allergies: ☐ NO ☐ YES If yes : _____

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
Xolair	☐ 75mg/0.5mL 27 Gauge PFS ☐ 150mg/mL 27 Gauge PFS ☐ 300mg/2mL Gauge PFS ☐ 75mg/0.5mL Autoinjector ☐ 150mg/mL Autoinjector ☐ 300mg/2mL Autoinjector	☐ Inject _____mg SUBQ every _____weeks		
Dupixent	☐ 300mg PFS ☐ 200mg PFS ☐ 300mg PFP ☐ 200mg PFP	**Starter Dose (if applicable)** ☐ Inject _____mg SUBQ once **Maintenance Dose** ☐ Inject _____mg SUBQ every __week(s)		
Fasenra	☐ 10mg/0.5mL PFS ☐ 30mg/mL PFS ☐ 30mg/mL Autoinjector	☐ _____mg SUBQ every 4 weeks for 3 doses, then once every 8 weeks ☐ 30 mg SUBQ every 4 weeks		
Tezspire	☐ 210mg/1.91mL PFS ☐ 210mg/1.91mL PFP	☐ 210mg SUBQ every 4 weeks		
Nucala	☐ 40mg/0.4mL PFS ☐ 100mg/mL Autoinjector ☐ 100mg/mL PFS	☐ _____mg SUBQ every 4 weeks		

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