

## FASENRA ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: \_\_\_\_\_

### Patient Information

Patient Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:	Phone:	Email:
Height (in):	Weight (lb):	Referral Status: <input type="checkbox"/> New <input type="checkbox"/> Updated <input type="checkbox"/> Renewal

### Infusion/ Injection Information

Primary ICD-10 Code:	Primary ICD-10 Description:
Other ICD-10 Codes:	Other ICD-10 Descriptions:

#### Leqvio (Inclisiran) Dosing Info:

- Initial Dosing, 30mg SQ Every 4 Weeks x3 Doses
- Maintenance Dosing, 30mg SQ Every 8 Weeks
- Patient is dependent on oral corticosteroids

#### Premedications:

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\_\_\_\_\_

#### Required Documentation:

- Full Patient Chart
- Insurance Cards (Front and Back)
- Clinical Notes Supporting Diagnosis
- List of Current Medications, Conditions, and Allergies
- Absolute Eosinophil Count (>300 in prior 12 months or >150 in prior 6 months)

### Ordering Provider Information

Practice Name:	Practice Phone:	Practice Fax:
Practice Address:	Referral Coordinator Name:	
Referral Coordinator Email:	Referral Coordinator Phone:	
Ordering Provider:	Provider NPI:	Specialty:

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date