Allergy/Immunology Referral Form	**Century Specialty Script** **Fax Referral To: 877-521-5353** **Phone: 800-521-3949**	
Date: ________________		

Patient Information	**Prescriber Information**
Patient Name: ____________________	Prescriber Name: ____________________
Address: ____________________	Address: ____________________
City, State, Zip: ____________________	City, State, Zip: ____________________
Home Phone: ____________________	Phone: ____________________
Cell Phone: ____________________	Fax: ____________________
DOB: ____________________	DEA: ____________________ NPI #: ____________________
Gender: ☐ M ☐ F	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:** ________________________

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