Allergy / Immunology
Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)
ICD-10 Code: _____
ICD-10 Description: _____ ☐ Other: _____

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
- Cetirizine (Zyrtec) 10mgPO
- Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
- Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
- Other: _____ Dose: _____ Route: _____

Medication	Dose	Directions	QTY	Refills
☐ Cinqair (Reslizumab)	100mg/10ml Vial	Infuse 3mg/kg IV every 4 weeks over 20-50 mins		
☐ Fasenra (Benralizumab)	☐ 30 mg/ml PFS ☐ 30 mg/ml Pen ☐ No preference	Initial Dose: Inject 30mg SC every 4weeks for 3 doses Maintenance Dose: Inject 30mg SC every 8 weeks		
Immune Globulin ☐ No preference ☐ Preferred Product Name:_____	☐ _____ gm(s) or _____gm(s)/kg IV daily for _____ day(s) every _____ ☐ _____ total gm(s) IV over _____ day(s) every_____ week(s) ☐ Other: _____	☐ Infuse IV over _____ hours ☐ Infuse IV per manufacturer's guidelines		
☐ Nucala (Mepolizumab)	☐ 40mg/0.4ml PFS ☐ 100mg/ml PFS ☐ 100 mg Vial	☐ Inject 100mg SC once every 4 weeks ☐ Inject 300mg SC once every 4 weeks		
☐ Tezspire (Tezepelumab-ekko)	210 Vial/PFS	Inject 210 SC every 4 weeks		
☐ Xolair (Omalizumab)	☐ 75mg PFS Syringe ☐ 150mg PFS Syringe ☐ 150mg Vial	☐ Inject _____mg SC every _____ weeks		
☐ Other:_____				

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.
Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

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Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**