Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Fasenra Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)228-9798 Attn: Idyllic Infusion Coordinator

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI Tax ID#	**Name: NPI: Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Contact Email	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY_____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: Weight in lbs:	
Insurance(s): include copies of front and back	
Preferred Treatment Location	☐ Voorhees ☐ Moorestown ☐ Wall/Manasquan ☐ Sewell ☐ Hamilton ☐ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

Name (last, first) _____DOB: _____

Diagnosis:
☐J45.50 Severe persistent asthma, uncomplicated
☐J45.51 Severe persistent asthma with (acute) exacerbation

Please answer all questions and provide supporting documentation.

- Is the patient 12 years old or older? _____
- What type of asthma does the patient have:
  ☐allergic ☐steroid-dependent ☐eosinophilic ☐Other, please list _____
- Does the patient have asthma symptoms throughout the day? _____
- Does the patient have a baseline blood eosinophil count of 150 cells/mcl or higher while on a steroid?_____
- Does the patient have an eosinophil count of 150 cells/mcl or higher in the past 6 weeks? _____ Higher than 300 cells/mcl every? _____
- On Steroids:
  - Does the patient have an FeNO of ≥ 20 ppb? _____
  - Does the patient have sputum eosinophil of ≥ 2%? _____
- Is the patient's asthma inadequately controlled on medium to high inhaled steroids plus an additional inhaled medication? _____
- Does the patient have ≥ 2 exacerbations per year requiring oral steroid treatment? _____
- Has the patient failed on or contraindicated for Xolair, Cinqair, Dupixent, Tezspire or Nucala?_____
  - If yes, provide details. _____
- Will the patient be concurrently treated with Xolair, another IL-5 antagonist, Dupixent or Tezspire? _____
- Will the patient be concurrently treated with any other asthma medications? _____
  - If Yes, which? _____
- Fasenra is not approved for bronchospasm or status asthmaticus. Will the patient be using Fasenra for either of these conditions? _____
- Please provide documentation of the baseline clinical status, including forced expiratory volume and # of exacerbations in the past 6 months, steroid use in the past 6 months.

For all patients:
- OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
- Does the patient have a history of anaphylaxis? _____
- Is this patient ambulatory ?
  - If no, is a wheelchair required _____
- Please include a copy of a prescription. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- Please notify our office if medication will be discontinued.

❒ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature _____