

ASTHMA AGENTS

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description) _____

Date of Diagnosis: _____

PRESCRIPTION ORDERS

- a) WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY 10 %
- b) Pretreatment Serum IgE (Xolair) _____

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	XOLAIR	<input type="checkbox"/> 150 mg <input type="checkbox"/> 225 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 375 mg	SQ	Every _____ days	
<input type="checkbox"/>	FASENRA (LOADING DOSES)	30 mg	SQ	Every 4 weeks for 3 doses, then every 8 weeks	
<input type="checkbox"/>	FASENRA (MAINTENANCE DOSES)	30 mg	SQ	Every 8 weeks	
<input type="checkbox"/>	NUCALA	100 MG	SQ	Every 4 weeks	
<input type="checkbox"/>	TEZSPIRE	210 mg	SQ	Every 4 weeks	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BENADRYL		
<input type="checkbox"/>	ACETAMINOPHEN		
<input type="checkbox"/>	OXYGEN		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	BUN/CREATININE	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CRP:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	ESR:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	Other:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	

NOTES/SPECIAL INSTRUCTIONS:

Physician's Signature _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.