

Phone:

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		City/State/Zip:	
Home Phone:		Cell Phone:	
Secondary Contact:		Work Phone:	
Patient Diagnosis & ICD-10:		Height: Weight:	
Allergies:		☐ Male ☐ Female	
PROVIDER INFORMATION			
Physician Name:		Lic.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
Office Contact:		City/State/Zip:	
Supervisory Physician (if applicable):		Phone: Fax:	
PLEASE ATTACH			
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)		☐ Eosinophil levels (<i>Fasenra, Cinqair and Nucala only</i>)	
☐ Recent office visit notes, history & physical, lab & pertinent procedure results		☐ Alpha-1 antitrypsin levels (<i>Aralast and Glassia only</i>)	
☐ Current medication list & list of prior medications tried and failed (with dates)		☐ FEV1 score (<i>Aralast and Glassia only</i>)	
☐ Documentation on phenotype (<i>Aralast and Glassia only</i>)		☐ Current Smoker? ☐ Yes ☐ No (<i>Aralast and Glassia only</i>)	
☐ Chest x-ray results (<i>Aralast and Glassia only</i>)		☐ Line access documentation/verification if applicable	
☐ CT scan results (<i>Aralast and Glassia only</i>)		☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
☐ IgA level (<i>Aralast and Glassia only</i>)			
NURSING & LAB ORDERS			
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
Flush Orders: <i>NaCl 0.9%</i> - 5-10mL flush pre and post infusion and as needed <i>Heparin</i> - ☐ 10units/mL ---OR--- ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line			
Lab Orders: Lab Date & Frequency:			
PRESCRIPTION ORDERS			
Anaphylaxis Kit: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed			
(Check all that apply) ☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other			
Pre-Medications: ☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV _____ minutes prior to infusion			
(Check all that apply) ☐ Diphenhydramine _____ mg ☐ PO ---OR--- ☐ IV infusion _____ minutes prior to infusion ☐ Other			
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given? _____ When is patient due for next dose? _____			
☐ ARALAST	60mg/kg IV infusion via ☐ gravity ---OR--- ☐ pump once weekly over approximately 15 minutes <i>*Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch</i>		_____
☐ CINQAIR	3mg/kg IV infusion via ☐ gravity ---OR--- ☐ pump once every 4 weeks over 20-50 minutes		_____
☐ FASENRA	☐ Induction: 30mg SubQ injection every 4 weeks for the first 3 doses		NONE
	☐ Maintenance: 30mg SubQ injection once every 8 weeks		_____
☐ GLASSIA	60mg/kg IV infusion via ☐ gravity ---OR--- ☐ pump once weekly over approximately 15 minutes <i>*Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch</i>		_____
☐ NUCALA	☐ 100mg SubQ injection every 4 weeks ☐ 300mg SubQ injection every 4 weeks		_____
☐ TEZSPIRE	210mg SubQ injection once every 4 weeks		_____
☐ XOLAIR	_____ mg SubQ injection every _____ weeks		_____
☐ ZEMAIRA	60mg/kg IV infusion via ☐ gravity ---OR--- ☐ pump once weekly over approximately 15 minutes <i>*Administer at ~0.08 mL/kg/minute (rate may be increased or decreased based on patient comfort)</i>		_____
☐ OTHER			_____

Prescriber's Signature
Dispense as Written

Print Name _____

Date _____

Prescriber's Signature
Substitution Permitted

Print Name _____

Date _____