

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

1. **Diagnosis:** ☐ J45.40 Moderate or ☐ J45.50 Severe: Persistent Asthma, uncomplicated
☐ J45.41 Moderate or ☐ J45.51 Severe: Persistent Asthma with acute exacerbation
☐ J45.42 Moderate or ☐ J45.52 Severe: Persistent Asthma with status asthmaticus
☐ Other: _____
2. **Patient has moderate to severe asthma that requires add on maintenance treatment?** ☐ Yes ☐ No
Eosinophil levels (if available) _____ cells / mcl Test Date: _____
3. **Atopic Comorbidities?** ☐ Yes ☐ No Specify: _____
IgE level (if available) _____ Test Date: _____
4. **Failed Medications and Duration:**
Inhaled Corticosteroids (without LABA): _____
Oral and / or Injectable Corticosteroids: _____
Combination therapy (ICS / LABA): _____
Other Controllers: _____
5. **Negative TB Skin Test (PPD Test):** ☐ Yes ☐ No When: _____ **** Please attach results****

Pre-Medication Orders:

- ☐ APAP ☐ 325mg ☐ 500mg ☐ 650mg - PO 30 minutes before infusion.
☐ Diphenhydramine ☐ 25mg ☐ 50mg - PO 30 minutes before infusion.
☐ 25mg IVP ☐ 50mg IVP
- ☐ Alternate Oral Antihistamines: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mg or ☐ 180mg
☐ Methylprednisolone ☐ 40mg IVP ☐ 125mg IVP or other _____ mg IVP
☐ Famotidine ☐ 20mg PO ☐ 40mg PO ☐ 20mg IVP ☐ 40mg IVP
☐ Ondansetron ☐ 4 mg IVP ☐ 4 mg PO

Labwork: _____ To be Drawn by: ☐ Infusion Clinic ☐ Referring Provider**Medication****Cinqair (reslizumab)**

Dosage / Frequency:

- ☐ Cinqair 3 mg / kg per 50-100 ml sodium chloride 0.9% IV to infuse over at least 30 minutes via pump with 0.22-micron filter every 4 weeks; followed each infusion with a 30-minute post observation period. **Maintenance Refills:** _____

Fasenra (benralizumab) - In AIC / HCP office administration only

Dosage / Frequency:

- ☐ Induction Dosage: Fasenra 30 mg SQ every 4 weeks for the first 3 doses given at week 0, week 4, week 8 and then followed by once every 8 weeks thereafter. **Maintenance Refills:** _____
- ☐ Maintenance: Fasenra 30 mg SQ injection every 8 weeks. **Maintenance Refills:** _____

Nucala (mepolizumab) - In AIC / HCP office administration only

Dosage / Frequency:

- ☐ Nucala 100 mg every 4 weeks via SQ injection in the upper arm, thigh, or abdomen **Maintenance Refills:** _____

Tezspire (tezepelumab – ekko) – In AIC / HCP office administration only

Dosage / Frequency:

- ☐ Tezspire 210 mg SQ injection every 4 weeks. **Maintenance Refills:** _____

Xolair (omalizumab) - In AIC / HCP office administration only

Dosage / Frequency:

- Xolair SQ every 2 weeks: ☐ 225 mg / dose ☐ 300 mg / dose ☐ 375 mg / dose
Xolair SQ every 4 weeks: ☐ 75 mg / dose ☐ 150 mg / dose ☐ 225 mg / dose ☐ 300 mg / dose **Maintenance Refills:** _____

Physician Prescription Orders Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ **Physician Signature:** _____ **Date:** _____