US infusions
11500 State Hwy 121 Ste 910, Frisco, TX 75035
P: 469-200-2605 F: 469-200-2606 usinfusions.org

PULMONARY INFUSION ORDER SET

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

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

DIAGNOSIS AND ICD-10 CODE:

☐ J45.51 – Severe persistent asthma with (acute) exacerbation

☐ J45.50 – Severe persistent asthma, uncomplicated

☐ J44.9 – Chronic obstructive pulmonary disease, unspecified

☐ M31.3 – Granulomatosis with polyangiitis

☐ M30.1 – Polyarteritis with lung involvement (Churg-Strauss)

☐ J33.9 – Nasal polyps, unspecified

☐ E88.01 – Alpha-1 Antitrypsin Deficiency

☐ D72.110 – Idiopathic hypereosinophilic syndrom (IHES)

☐ Other diagnoses: _____

PRESCRIPTION:

☐ ***Xolair:** Dosing range from 75mg to 600mg will be calculated based on weight, indication, and IgE level.

Frequency: ☐ every 2 weeks ☐ every 4 weeks Refills: ☐ 1yr ☐ Other: _____

☐ ***Cinqair:** Dose: ☐ 3mg/kg IV every 4 weeks Refills: ☐ 1yr ☐ Other: _____

☐ ***Fasenra:** ☐ Initial dose: 30mg subcutaneously every 4 weeks for the first 3 doses followed by 30mg subcutaneously every 8 weeks thereafter.

☐ Maintenance dose: 30mg subcutaneously every 8 weeks Refills: ☐ 1yr ☐ Other: _____

☐ ***Nucala:** Dose: ☐ 100mg ☐ 300mg subcutaneously every 4 weeks Refills: ☐ 1yr ☐ Other: _____

☐ **Tezspire:** Dose: ☐ 210mg subcutaneously every 4 weeks Refills: ☐ 1yr ☐ Other: _____

☐ ***Prolastin:** Dose: ☐ 60mg/kg IV weekly Refills: ☐ 1yr ☐ Other: _____

☐ ***Glassia:** Dose: ☐ 60mg/kg IV weekly Refills: ☐ 1yr ☐ Other: _____

☐ ***Rituximab:** Dose: ☐ 1000mg ☐ 375mg/m² ☐ Other: _____

Frequency: ☐ One-time dose ☐ Weekly x4 weeks ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____

THERAPIES TRIED AND FAILED, INTOLERANCES, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY:

_____

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

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PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

REQUIRED PRE-SCREENING:

Xolair for asthma and nasal polyps: ☐ Serum IgE level

Xolair for asthma: ☐ Skin/RAST test

Xolair: ☐ Epi-pen, Auvi-Q, Neffy

Cinqair, Fasenra, and Nucala: ☐ CBC w/ differential

Nucala: For EGPA - does the patient have a baseline peripheral blood eosinophil level of . ≥ 150 cells/mcL within the past 6 weeks? ☐ Yes ☐ No

For HES – does the patient have a baseline peripheral blood eosinophil level of ≤ 1000 cells/mcL within the past 4 weeks? ☐ Yes ☐ No

Prolastin and Glassia: ☐ Serum IgA ☐ Alpha1-antitrypsin level

Pulmonary Infections: ☐ Documentation of recurrent bacterial infections, history of failure to respond to antibiotics, and documentation of pre and post-pneumococcal vaccine titers.

Asthma: Does the patient have an ACQ score consistently >1.5 or ACT score consistently <20? ☐ Yes ☐ No

Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization, or ER visit within a 12mo period? ☐ Yes ☐ No

Does the patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL for (Nucala, Cinqair, Fasenra) or elevated IgE level >30 (Xolair) within the past 6 weeks? ☐ Yes ☐ No

FEV1 score (include report): _____

☐ Hepatitis B screening (antigen and core antibody total, not IgM) w/attached ☐ Positive ☐ Negative results
Required for: Rituximab

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list ☐ Labs and/or test results

☐ Clinical notes supporting the above diagnoses. ☐ PFT report.

☐ Clinical notes supporting contraindication/intolerance, or failed trial of conventional therapy or biologic.

☐ *If applicable* - Last know biological therapy: _____ and last date received: _____

☐ If switching to biologic therapy - please perform a wash-out period of _____ weeks prior to starting ordered biologic.

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606