US infusions

PULMONARY INFUSION ORDER SET

PULMONOLOGY ORDERS:

Patient Name: _____ DOB: _____ Phone: _____

☐ New to therapy ☐ Continuing therapy: next treatment date: _____.

MEDICAL INFORMATION:

☐ J45.40 – Moderate persistent asthma

☐ J45.5 – Severe persistent asthma

☐ J82.83 – Severe asthma with an eosinophilic phenotype

☐ M31.3 – Severe granulomatosis with polyangiitis

☐ J33.9 - Nasal polyps

☐ E88.01 - Alpha-1 Antitrypsin Deficiency

☐ L50.1 - Chronic Idiopathic Urticaria

☐ Other - _____

THERAPY ORDERS:

☐ ***Xolair**: Dosing range from 75mg to 600mg will be calculated based on weight, indication, and IgE level.
Frequency: □ every 2 weeks □ every 4 weeks Refill: □ 1yr □ Other: _____

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

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

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

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

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

***See opposite side for required pre-screening**

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

_____

_____

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

US infusions

PULMONOLOGY INFUSION ORDER SET

PULMONOLOGY ORDERS:

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 prescribed
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 <120? □ 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 within the past 6 weeks? □ YES □ NO
- FEV1 score (if applicable*)*: _____

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list ☐ Labs and/or test results
☐ Include clinical notes supporting the above diagnoses.
☐ Include 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.

REFERRING PROVIDER INFORMATION:

Provider name: _____ Signature:_____ Date:_____

NPI: _____ Phone: _____ Fax: _____

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