Specialty Infusion Services

ASTHMA BIOLOGICS ORDER FORM

YOUR OSO REPRESENTATIVE:

Name: _____

Phone: _____

Email: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Allergies: _____

Is patient pregnant? ☐ Yes ☐ No Patient's Height: _____ Patient's Weight (kg): _____

TB Test Preformed? ☐ Yes ☐ No Date of negative TB Test: _____

DIAGNOSIS INFORMATION:

☐ Moderate/Severe Persistent Asthma. Diagnosis Code: _____

☐ Other: _____ Diagnosis Code: _____

PRE-MEDICATION:

☐ Tylenol (Acetaminophen) 650 mg PO ☐ Benadryl 25 mg PO ☐ Zyrtec 10 mg PO ☐ Other: _____

☐ Benadryl 25 mg slow IVP ☐ Solu-medrol slow IVP ☐ 20mg ☐ 40mg ☐ 100mg

CINQAIR (RESLIZUMAB)

☐ 3 mg/kg IV every 4 weeks x 1 year

☐ _____ mg/kg IV every _____ weeks x 1 year. Last Infusion Date: _____

FASENRA (BENRALIZUMAB)

☐ 30mg single dose prefilled syringe

☐ Every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter ☐ New Start ☐ Continuation: Every 8 weeks

☐ _____ mg/kg IV every _____ weeks x 1 year. Last Infusion Date: _____

NUCALA (MEPOLIZUMAB)

☐ 100 mg once every 4 weeks x 1 year

☐ _____ mg/kg IV every _____ weeks x 1 year. Last Infusion Date: _____

TEZSPIRE (TEZEPELUMAB-EKKO)

☐ 210 mg IV once every 4 weeks x 1 year

XOLAIR (OMALIZUMAB)

☐ 375 mg ☐ 300 mg ☐ 225 mg ☐ 150mg ☐ Other: _____

☐ SC every 2 weeks ☐ SC every 4 weeks

☐ _____ mg/kg IV every _____ weeks x 1 year. Last Infusion Date: _____

IN CASE OF REACTION

☒ Follow Oso Protocol for anaphylaxis & infusion reactions.

NURSING

☒ Oso to coordinate nursing services in Ambulatory Infusion Suite.

REQUIRED DOCUMENTATION

☐ Recent Office Notes (along with any therapies tried and outcomes)

☐ History and Physical Report (w/in past 6 months)

☐ Lab Results

☐ Insurance Cards (front and back)

☐ Demographic Sheet

☐ Current Medication List

PHYSICIAN INFORMATION

MD Name: _____ Office Contact: _____

Address: _____

Phone: _____ Fax: _____

MD Signature: _____ Date: _____