LIFE SPECIALTY SOLUTIONS

ASTHMA

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List 6. Tried/Failed Therapies

For Xolair: Positive skin test or in vitro reactivity to a perennial aeroallergen? ☐ Yes ☐ No Date of test _____

For renewal requests: What is the patient's most recent Eosinophil count _____ Date of test _____

Did the patient experience measurable improvement in disease activity and/or severity? ☐ Yes ☐ No (provide documentation)

PRIMARY DIAGNOSIS

☐ J45.40 Moderate persistent asthma, uncomplicated

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

☐ J45.901 Unspecified asthma with (acute) exacerbation

☐ Other _____

☐ J45.50 Severe persistent asthma, uncomplicated

☐ J45.901 Unspecified asthma with (acute) exacerbation

☐ J82.83 Eosinophilic asthma

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Xolair _____mg SubQ Injection every 2 weeks

☐ Tezspire 210mg SubQ Injection every 4 weeks

☐ Nucala 100mg SubQ Injection every 4 weeks

☐ Other _____

☐ Xolair _____mg SubQ Injection every 4 weeks

☐ Fasenra 30mg SubQ Injection at week 0, 4, 8, and every 8 weeks thereafter

☐ Cinqair 3mg/kg (_____mg) IV every 4 weeks

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE