

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____
 Patient Weight: _____ lbs. (required) Address: _____
 Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Next Treatment Date: _____

DIAGNOSIS

☐ Alpha-1 Antitrypsin Deficiency... ICD-10 Code: E88.01 ☐ Persistent Asthma..... ICD-10 Code: _____
☐ Chronic Idiopathic Urticaria..... ICD-10 Code: _____ ☐ Severe Asthma with Eosinophilic phenotype.... ICD-10 Code: _____
☐ Nasal Polyps..... ICD-10 Code: _____ ☐ Severe Granulomatosis with Polyangiitis..... ICD-10 Code: _____
☐ Other: _____ ICD-10 Code: _____

THERAPY ORDER

MEDICATION	ORDERS	REFILL	LAB ORDERS
☐ Cinqair	☐ 3mg/kg IV every 4 weeks		☐ Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks (asthma & EGPA) or ≥ 1000 cells/mcL within 4 weeks (HES)? ☐ Yes ☐ No ☐ FEV1 score if applicable: _____ ☐ Serum IgE level ☐ Asthma ☐ Nasal Polyps Xolair ☐ Skin/RAST test ☐ Asthma Xolair ☐ Serum IgA ☐ Prolastin ☐ Glassia ☐ Alpha1-antitrypsin (AAT) level ☐ Prolastin ☐ Glassia ☐ CBC w/ differential ☐ Cinqair ☐ Fasentra ☐ Nucala
☐ Fasentra	Initial Dose: ☐ 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30 mg Sub-Q every 8 weeks thereafter Maintenance Dose: ☐ 30 mg Sub-Q every 8 weeks		
☐ Glassia	☐ 60mg/kg IV weekly	☐ _____	
☐ Nucala	☐ 100mg Sub-Q every 4 weeks ☐ 300mg Sub-Q every 4 weeks	☐ x1 year	
☐ Prolastin	☐ 60mg/kg IV weekly		
☐ Tezspire	☐ 210mg Sub-Q every 4 weeks		
☐ Xolair	☐ 75mg Sub-Q ☐ 375mg Sub-Q ☐ 150mg Sub-Q ☐ 450mg Sub-Q ☐ 225mg Sub-Q ☐ 525mg Sub-Q ☐ 300mg Sub-Q ☐ 600mg Sub-Q Frequency: ☐ Every 2 weeks ☐ Every 4 weeks		
☐ Other	☐ _____		

Pre-Medications: _____

Additional Lab Orders: _____

Frequency: _____

PROVIDER INFORMATION

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

PRESCRIBER SIGNATURE

Prescriber's Signature: _____

Date: _____