

**Severe Asthma Prescriber Order Form**

<b>Patient Name:</b> _____	<b>Patient Phone:</b> _____	<b>DOB:</b> _____	<b>Gender:</b> _____
<b>Address:</b> _____	<b>City:</b> _____	<b>State:</b> _____	<b>Zip:</b> _____

**Primary Diagnosis**

J82 - Eosinophilic Asthma  
 Other (ICD-10 Code and Description): \_\_\_\_\_

**Clinical Background and Orders**

**1** Ht: \_\_\_\_\_  in  cm Wt: \_\_\_\_\_  lb  kg Date: \_\_\_\_\_ Code Status: \_\_\_\_\_ IV Access: N/A or \_\_\_\_\_  
 Allergies:  NKDA OR (list): \_\_\_\_\_  
**Please attach the following: Patient demographics, insurance information, History and Physical, and medication list**

**2**  **Cinqair® (Reslizumab) Prescription:**  
 3 mg/kg IV over 20 - 50 minutes every 4 weeks; Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Catheter Maintenance, Supply, and Nursing Orders:**  
 Provide all supplies necessary to administer therapy  
 Skilled nurse to administer medication in the alternate treatment site (ATS), establish and/or maintain IV access, monitor and treat ADRs, and administer medications as ordered. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.  
 If applicable, flush intravenous access device per below protocol:

Access Device Flush Protocol	0.9% Sodium Chloride Flush	Heparin
Peripheral	2 - 3 ml pre/post use	1 - 3 ml (10 units/ml) post use; maintenance q24hr
Peripheral - Midline	3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (10 units/ml) post use; maintenance 3ml 10 units/ml q12hr or 3ml 100 units/ml q24hr
PICC & Central Tunneled & Non-tunneled	5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (100 units/ml) or 5 ml (10 units/ml) post use; maintenance q24hr
Implanted Port	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw	3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3 - 5 ml weekly to monthly
Valved Catheters: Chest, PICC, Midline	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

**Nucala® (Mepolizumab) Prescription:**  
 100 mg subcutaneously every 4 weeks; Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Supply and Nursing Orders:**  
 Provide all supplies necessary to administer therapy  
 Skilled nurse to administer medication in the home/alternate care setting, monitor and treat ADRs, and administer medications as ordered.

**3**  **Adverse Reaction Orders:**

- Epinephrine 1:1000 1 mg/ml ampule/vial. Administer one dose IM PRN for severe hypersensitivity reaction/anaphylaxis. Repeat once PRN. Qty: 2
- Diphenhydramine 25 mg PO PRN mild allergic reaction. Qty: 2 (tablets or liquid 118ml bottle)
- Diphenhydramine 50 mg/ml IM/IV vial PRN moderate allergic reaction. Qty: 1
- Sodium Chloride 0.9% 250 ml bag. RN to start PIV and administer PRN for anaphylaxis or hypotension. Qty: 1
- Dispense supplies as needed to administer the above medications.
- If needed, call EMS, and contact physician for severe anaphylaxis.

**Other:** \_\_\_\_\_

**4 Lab Orders:** \_\_\_\_\_

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
Physician Name: _____	Office Contact: _____
Address: _____	Direct contact number/extension: _____
City: _____ State: _____ Zip: _____	
Phone: _____ Fax: _____	

**Fax completed form, insurance information, and clinical documentation to: 713-983-4647**

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