

Severe Asthma Prescriber Order Form

Patient Name: _____		Patient Phone: _____		DOB: _____	Gender: _____																	
Address: _____			City: _____	State: _____	Zip: _____																	
Primary Diagnosis																						
<input type="checkbox"/> J82 - Eosinophilic Asthma <input type="checkbox"/> Other (ICD-10 Code and Description): _____																						
Clinical Background and Orders																						
1	Ht: _____ <input type="checkbox"/> in <input type="checkbox"/> cm Wt: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Date: _____ Code Status: _____ IV Access: N/A or _____ Allergies: <input type="checkbox"/> NKDA OR (list): _____																					
	Please attach the following: Patient demographics, insurance information, History and Physical, and medication list																					
2	<input type="checkbox"/> 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:																					
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Access Device Flush Protocol</th> <th style="width:40%;">0.9% Sodium Chloride Flush</th> <th style="width:35%;">Heparin</th> </tr> </thead> <tbody> <tr> <td>Peripheral</td> <td>2 - 3 ml pre/post use</td> <td>1 - 3 ml (10 units/ml) post use; maintenance q24hr</td> </tr> <tr> <td>Peripheral - Midline</td> <td>3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw</td> <td>3 ml (10 units/ml) post use; maintenance 3ml 10 units/ml q12hr or 3ml 100 units/ml q24hr</td> </tr> <tr> <td>PICC & Central Tunneled & Non-tunneled</td> <td>5 ml pre/post use; 5 ml pre/10 ml post lab draw</td> <td>3 ml (100 units/ml) or 5 ml (10 units/ml) post use; maintenance q24hr</td> </tr> <tr> <td>Implanted Port</td> <td>5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw</td> <td>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</td> </tr> <tr> <td>Valved Catheters: Chest, PICC, Midline</td> <td>5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly</td> <td style="text-align: center;">N/A</td> </tr> </tbody> </table>					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
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3	<input type="checkbox"/> 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.																					
	<input type="checkbox"/> Adverse Reaction Orders: <ul style="list-style-type: none"> • 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. <input type="checkbox"/> Other: _____																					
4	Lab Orders:																					
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>																						
Prescriber Signature: _____ Date: _____																						
Physician Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____				Office Contact: _____ Direct contact number/extension: _____																		
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