

**Patient Information**

Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

**Additional Information Needed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs                 |
| <input type="checkbox"/> Fax patient demographics         | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> Fax TB and Hep B results |

**Diagnosis and Clinical Information**
**Diagnosis (ICD-10):**

- J45.5 Severe Persistent Asthma  
 J45.50 Severe Persistent Asthma, Uncomplicated  
 J45.51 Severe Persistent Asthma with Acute Exacerbation  
 J45.52 Severe Persistent Asthma with Status Asthmaticus  
 Other: Code: \_\_\_\_\_ Description: \_\_\_\_\_

**Clinical Information:**

- New Therapy Induction     Therapy Change     Therapy Continuation  
 Patient Weight: \_\_\_\_\_ lbs / \_\_\_\_\_ kg     Patient Height: \_\_\_\_\_ in / \_\_\_\_\_ cm  
 Allergies: \_\_\_\_\_  
 Therapies Tried and Failed: \_\_\_\_\_  
 TB Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_     Hep B Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Has patient had positive skin test to perennial aeroallergen?     Yes     No    Test Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Has patient had positive RAST test?     Yes     No    Test Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Has patient had pre-treatment IgE serum?     Yes     No    Test Date: \_\_\_\_\_ Level: \_\_\_\_\_

**Lab Orders**

- CBC     CMP     ESR     CRP     Total IgE  
 Other: \_\_\_\_\_

**Lab Orders to be done by**

- Oklahoma Infusion Services  
 Referring Provider

**Prescription Information**

- Cinqair     Dose: 3mg/kg     Frequency: every 4 weeks

**Pre-Medication Orders**

- Solu-Cortef 50-100mg SIVP     Benadryl 25mg PO PRN  
 Tylenol tablet 500-1000mg PO PRN     Other: \_\_\_\_\_

**Standing Orders for Adverse Reactions**

- Stop infusion and initiate NS bolus     Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis  
 Notify supervising physician and ordering provider     Oxygen 2-5L nasal cannula  
 Solu-Cortef 100mg SIVP signs of adverse reaction     Albuterol 2.5mg inhaled PRN for chest tightness  
 Benadryl 25mg SIVP for hives or bronchial inflammation     Other: \_\_\_\_\_

**Prescriber Information**


Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:


Prescriber's Signature: \_\_\_\_\_


Date: \_\_\_\_\_

*By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.*

Please fax form to: 405-726-9849

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