SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

ASTHMA AGENT ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:_______________

HT: __________ in WT: ________ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):______________________________

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Provider Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID #:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

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Date of Diagnosis: ____________________

PRESCRIPTION ORDERS

a) WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY 10 %

b) Pretreatment Serum IgE (Xolair) ________________________ units / mL

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	XOLAIR	____ 150 mg ____ 225 mg ____ 300 mg ____ 375 mg	Sub Q	Every ________ Weeks	
	FASENRA (LOADING DOSES)	30 mg	Sub Q	Every 4 weeks for 3 doses, then every 8 weeks	
	FASENRA (MAINTANENCE DOSES)	30 mg	Sub Q	Every 8 weeks	
	NUCALA	100 MG	Sub Q	Every 4 weeks	
	TEZSPIRE	210 mg	Sub Q	Every 4 weeks	

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL (diphenhydramine)		
	TYLENOL (acetaminophen)		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	NONE	NA	NA
	BMP	( ) PRIOR ( ) POST	
	CMP	( ) PRIOR ( ) POST	
	BUN/CREATININE	( ) PRIOR ( ) POST	
	CRP:	( ) PRIOR ( ) POST	
	ESR:	( ) PRIOR ( ) POST	
	Other:	( ) PRIOR ( ) POST	

NOTES:

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Physician's Signature ______________________________ **Time**__________________ **Date**______________

**Signature Must Be Clear and Legible*

Cosignature (If Required)______________________________ **Time**__________________ **Date**______________

**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.