



| Patient Information                                    | Prescriber Information                |
|--------------------------------------------------------|---------------------------------------|
| Name: <input type="text"/>                             | Prescriber Name: <input type="text"/> |
| DOB: <input type="text"/>                              | NPI: <input type="text"/>             |
| Address: <input type="text"/>                          | Address: <input type="text"/>         |
| City: <input type="text"/> State: <input type="text"/> | City: <input type="text"/>            |
| Zip: <input type="text"/> Weight: <input type="text"/> | State: <input type="text"/>           |
| Phone: <input type="text"/>                            | Phone: <input type="text"/>           |
| Allergies: <input type="text"/>                        | Fax: <input type="text"/>             |

| Diagnosis (please provide ICD-10 code in space provided):                                                                |
|--------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Asthma <input type="checkbox"/> Immunodeficiency <input type="checkbox"/> Hypogammaglobulinemia |
| Other: <input type="text"/>                                                                                              |

**Nursing Orders: Hold infusion and notify provider for:**

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles.

If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

| Drug                      | Dosing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Immunoglobulin            | <input type="checkbox"/> IV <input type="checkbox"/> SubQ<br><input type="text"/> mg/kg OR <input type="text"/> gm/kg x <input type="text"/> day(s) OR divided over <input type="text"/> day(s)<br>Frequency: Every <input type="text"/> weeks OR <input type="text"/><br>(Allied to choose if not indicated) Brand: <input type="text"/><br>Additional orders: <input type="text"/>                                                                                                           |
| Cinqair<br>(reslizumab)   | <input type="checkbox"/> 3mg/kg IV every 4 weeks                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Fasenra<br>(benralizumab) | <input type="checkbox"/> 30mg SubQ every 4 weeks for the first 3 doses followed by 30mg SubQ every 8 weeks thereafter<br><input type="checkbox"/> 30mg SubQ every 4 weeks<br><input type="checkbox"/> 30mg SubQ every 8 weeks                                                                                                                                                                                                                                                                  |
| Nucala<br>(mepolizumab)   | <input type="checkbox"/> 100mg SubQ every 4 weeks<br><input type="checkbox"/> 300mg SubQ every 4 weeks                                                                                                                                                                                                                                                                                                                                                                                         |
| Tezspire<br>(tezepelumab) | <input type="checkbox"/> 210mg SubQ every 4 weeks                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Xolair<br>(omalizumab)    | <div><div><input type="checkbox"/> 75mg SubQ<br/><input type="checkbox"/> 150mg SubQ<br/><input type="checkbox"/> 225mg SubQ<br/><input type="checkbox"/> 300mg SubQ<br/><input type="checkbox"/> 375mg SubQ<br/><input type="checkbox"/> 450mg SubQ<br/><input type="checkbox"/> 525mg SubQ<br/><input type="checkbox"/> 600mg SubQ</div><div><input type="checkbox"/> Every 2 weeks<br/><input type="checkbox"/> Every 4 weeks<br/><input type="checkbox"/> <input type="text"/></div></div> |

| Premedications:                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Tylenol 650mg PO <input type="checkbox"/> Benadryl 25mg IV or PO <input type="checkbox"/> Solu-Medrol IV 40mg, 125mg or <input type="text"/> mg              |
| <input type="checkbox"/> Other: <input type="text"/> IV or PO                                                                                                                         |
| Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability. |

Prescriber Name (Please print):  Contact Person:

Prescriber Signature:  Date:

**Please include a copy of the latest insurance information as well as all applicable clinical notes.**

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.