Birmingham ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

CINQAIR (Reslizumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

____ Severe Eosinophilic Asthma

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

CINQAIR ORDERS/DOSAGE: _____ 3mg/kg IV every 4 weeks

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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FASENRA (Benralizumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

____ Eosinophilic Asthma

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

FASENRA ORDERS/DOSAGE:

_____ Initial dose - 30mg every 4 weeks for the first 3 doses and then every 8 weeks

_____ 30mg every 8 weeks for Maintenance dose _____ _____(other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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NUCALA (Mepolizumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

____ Severe Eosinophilic Asthma

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

NUCALA ORDERS/DOSAGE:

_____ 100mg SQ every 4 weeks

_____ 300mg SQ as separate 100mg injections every 4 weeks _____ _____ (other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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XOLAIR (Omalizumab) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes & labs (Serum IgE).

DIAGNOSIS (Please provide ICD-10 code):

_____ Allergic Asthma _____ Chronic Idiopathic Urticaria _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

XOLAIR ORDERS/DOSAGE:

_____ 150mg _____ 225mg _____300mg _____375mg _____ _____(other)

FREQUENCY: _____ Every 2 weeks _____ Every 4 weeks _____ _____(other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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Infusion Order for Medication (Print) _____

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs.

DIAGNOSIS (Please provide ICD-10 code): _____

____ _____

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

___ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____