Comanche County Memorial Hospital

**Outpatient Infusion Center
Fasenra Order**

Please fax form to: 580-585-5472

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Gender: M F

Patient Address: _____ Email: _____ Insurance: _____

Additional Information Needed

Fax front/back of insurance card	Fax clinical/progress notes	Fax labs
Fax patient demographics	Fax current medication list	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
K45.52 Severe Persistent Asthma with Status Asthmaticus
Other: DX: _____

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 the patient had a positive skin test to perennial aeroallergen? Yes or No Test Date:_____ Results: _____
Has the patient had a positive RAST test? Yes or No Test Date:_____ Results: _____
Has the patient pre-treatment IgE serum? Yes or No Test Date: _____ Level: _____

Lab Orders

Lab Orders	Lab Orders to be done by
CBC w/o diff CMP ESR CRP Total IgE	Infusion Services
Other: _____	Referring Provider

Prescription Information

Fasenra	Intial Dose: 30mg/mL Prefilled syringe beginning week, week 4 and week 8
	Maintenance Dose: 30mg/mL Prefilled syringe every 8 weeks after week 8

Misc Orders

_____ _____	PICC/Midline/CAD dressing to be changed every 7 days
	Flushes
	10mL NS Flush Syringe PRN
	Heparin 500units/5mL Flush Syringe PRN
	50ml NS Bag PRN
	250ml NS Bag PRN

Standing Orders for Adverse Reaction

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 to chest tightness
Benadryl 25 mg SIVP for hives or bronchial inflammation	Other: _____

Prescriber Information

Physician Name: _____ Official Contact Name: _____

Contact #: _____ Fax Number: _____

Address: _____ City/State/Zip: _____

NPI#: _____ DEA#: _____ State License #: _____

_____   _____   _____
Physician's Signature   Date   Time