AYSA
THERAPEUTICS INFUSION

PULMONARY ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ______________________ DOB: ____________ Phone: ______________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: __________ lbs. Allergies: ______________________________

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ______________________________

FASENRA INJECTION

☐ **Severe Asthma with Eosinophilic phenotype** (ICD-10 _________)

Fasenra Initial Dose: ☐ 30mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter

Fasenra Maintenance Dose: ☐ 30mg subcutaneously every 8 weeks

XOLAIR INJECTION

☐ Allergic Asthma (ICD-10:) _________ ☐ ______________________________

Xolair Dose: ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg **Frequency:** Subcutaneously every: ☐ 2 weeks or ☐ 4 weeks

History: Positive Skin or RAST Test: ☐ Yes ☐ No Test date: ____________

Pre-Treatment IgE Serum: _________ IU/mL Test date: ____________

**** Date of last Xolair Injection:** ______________ *Note: Patient must have an EpiPen in their possession at every appointment.*

PROLASTIN INJECTION

☐ **Alpha-1 Antitrypsin Deficiency (ICD-10 ___________)** ☐ **Panacinar Emphysema (ICD-10 ____________)**

Prolastin Dose: ☐ 60mg/kg IV weekly **OR** ☐ Other: ______________________

Premedication: ______________________________

**** Date of last Prolastin Infusion:** ______________

GLASSIA INJECTION

☐ **Alpha-1 Antitrypsin Deficiency (ICD-10 ___________)**

Glassia Dose: ☐ 60mg/kg IV weekly **OR** ☐ Other: ______________________

**** Date of last Glassia Infusion:** ______________

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ____________________ Physician Name: ____________________ Date: __________

Phone: __________________ Fax: __________________ Contact Person: ____________________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately. If you have received this in error, destroy the document immediately.

© At Your Service Anesthesia, Inc. 2022