Premier Health
Anti-Asthmatic Monoclonal Antibody Faxed Order Form

Patient Name _____ Date of Birth _____

Patient MRN# _____Patient's Allergies _____

Ordering Physician_____ Physician's Phone/Fax #_____/_____

Infusion Center Fax Numbers:

MVH Middletown: 513-974-5023 MVH North: 937-641-2378 MVH South: 937-641-2676
MVH Troy: 937-440-4503 MVH Greenville: 937-641-7205

PLEASE HAVE PATIENT BRING CURRENT MEDICATION LIST

Diagnosis: ☐ Severe Persistent Asthma, uncomplicated (J45.50) ☐ Moderate Persistent Asthma, uncomplicated (J45.40)
☐ Severe Persistent Asthma w/ Acute Exacerbation (J45.51)
☐ Eosinophilic Asthma (J82.83) ☐ Other: _____

PHYSICIAN ORDERS:

PREMEDICATIONS:

☐ _____

☐ _____

Anti-IgE Agent

For patients receiving omalizumab please verify with the provider that the patient has a prescription for an epinephrine auto-injector (Epi-Pen) for post-discharge anaphylactic reactions prior to scheduling the patient.

Ensure the patient has an in-date epinephrine auto-injector and understands when and how to use it prior to administration of omalizumab. If the patient did not bring their epinephrine autoinjector to their appointment or if it is expired contact the provider for additional orders.

☐ **Xolair (Omalizumab) (Preferred PH Agent)**

DOSE: _____(Subcutaneous) FREQUENCY:_____

MONIITORING DURATION: ☐ 2 Hours after the first 3 injections, then 30minutes for subsequent injections
☐ Other: _____

Interleukin-5 Inhibitors

☐ **Fasenra (Benralizumab) (Preferred PH agent)**
DOSE: 30mg Subcutaneous ☐ q4 weeks x3 doses ☐ q8weeks ☐ other :_____

☐ Cinqair (Reslizumab)

DOSE: ☐ 3mg/kg IV q4weeks Patient weight:_____ ☐ other: _____
ADMINISTRATION: Doses will admixed in a total volume of 50ml of 0.9% Sodium Chloride
(Initial infusion to run over 50 minutes, subsequent infusion can run over 20 minutes)

☐ Nucala (Mepolizumab)
DOSE: ☐ 100mg Subcutaneous q4weeks ☐ other:_____

Anti-Human Thymic Stromal Lymphopoietin (Anti-TSLP) Agent

☐ Tezspire (Tezepelumab)
DOSE: ☐ 210mg Subcutaneous q4weeks ☐ other:_____

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ADDITIONAL ORDERS FOR BENRALIZUMAB, MEPOLIZUMAB,OMALIZUMAB & TEZEPELUMAB ADMINISTRATION

NURSING:

√ Vital signs baseline.

√ Observe for hypersensitivity reactions after administration.

√ Check vitals immediately after administration, then 30 minutes post administration.

MILD / MODERATE REACTION MEDICATIONS:

√ Diphenhydramine 25 mg PO Once as needed for itching/hives with mild/moderate reactions

√ Acetaminophen 650 mg PO Once as needed for headache, malaise, fever, and mild pain with mild/moderate reactions. (unless already pretreated)

EMERGENCY MEDICATIONS FOR SEVERE/ANAPHYLACTIC REACTION:

√ For Anaphylaxis/Severe Reaction- Place patient supine position. Assess airway, breathing, circulation, and mentation. Monitor vital signs (including O2 saturation every 5 minutes).

√ Notify provider for anaphylactic / severe reactions.

√ For Anaphylaxis/Severe Reaction- Administer oxygen per nasal cannula or mask as needed to maintain O2 saturations >90%

√ Epinephrine 1:1000 0.3 mg IM every 5 minutes x 3 PRN for severe reaction / anaphylaxis.

√ Diphenhydramine 50 mg IV push Once PRN for severe reaction / anaphylaxis.

√ Famotidine 20 mg IV push Once PRN for severe reaction / anaphylaxis.

√ Methylprednisolone 125mg IV push Once PRN for severe reaction / anaphylaxis.

√ NaCl 0.9% 1000 ml at 10-999 ml/hr continuous PRN -- Admin Inst: : for severe reaction / anaphylaxis until symptoms resolve.
√ For Anaphylaxis/Severe Reaction- Insert Saline Lock

- √ Insert Saline Lock- For Anaphylaxis/Severe Reaction
- √ Flush Saline Lock PRN- For Anaphylaxis/Severe Reaction
- √ Discontinue Saline Lock on discharge if present

ADDITIONAL ORDERS FOR RESILIZUMAB ADMINISTRATION

NURSING:

√ Vital signs baseline, then 5 minutes after infusion has started then every 30 minutes.

√ Observe for hypersensitivity reactions during infusion – this includes hypotension, shortness of breath, and rash.

√ Check vitals immediately after completion, then 30 minutes post infusion. The patient must be observed for at least 30 minutes after completion of the iron infusion for hypersensitivity reactions.

√ Discontinue IV and discharge patient upon completion of therapy.

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IV SALINE LOCK PANEL / CARRIER FLUID (for Reslizumab)

√ Insert Saline Lock

√ Saline Lock flush 10ml 0.9% NaCl - as needed for line flush

√ Discontinue Saline Lock on discharge

√ NaCl 0.9% 1000 ml at 10 ml/hr Once PRN -- Admin Inst: : If infusion rate is less than 10 ml/hr or the infusion is a vesicant or a continuous IV solution is not infusing, a carrier fluid of 0.9% NaCl at 10 ml/hr may be initiated during infusion. DC Carrier fluid when infusion complete

MILD / MODERATE REACTION MEDICATIONS:

√ For Mild/Moderate Infusion Reaction- Stop infusion. Maintain vascular access. Monitor vitals every 10 minutes. Once symptoms resolve, infusion may be restarted at ordered rate.

√ Diphenhydramine 25 mg PO push Once as needed for itching/hives.

√ Acetaminophen 650 mg PO Once as needed for headache, malaise, fever, and mild pain. (unless already pretreated)

√ 0.9% NaCl 1000ml at 500 mL per hour Continuous PRN For mild/moderate reaction until symptoms resolve, then resume infusion.

EMERGENCY MEDICATIONS FOR SEVERE/ANAPHYLACTIC REACTION:

√ For Anaphylaxis/Severe Reaction- Immediately discontinue drug infusion. Place patient supine position. Assess airway, breathing, circulation, and mentation. Monitor vital signs (including O2 saturation every 5 minutes).

√ Notify provider for anaphylactic / severe reactions.

√ For Anaphylaxis/Severe Reaction-Administer oxygen per nasal cannula or mask as needed to maintain O2 saturations >90%

√ Epinephrine 1:1000 0.3 mg IM every 5 minutes x 3 PRN for severe reaction / anaphylaxis.

√ Diphenhydramine 50 mg IV push Once PRN for severe reaction / anaphylaxis.

√ Famotidine 20 mg IV push Once PRN for severe reaction / anaphylaxis.

√ Methylprednisolone 125mg IV push Once PRN for severe reaction / anaphylaxis.

√ 0.9% NaCl 1000 ml at 999 ml/hr Continuous PRN for severe reaction / anaphylaxis until symptoms resolve.

Provider signature_____

Printed provider name_____

Date_____ Time _____

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For Completion by Prior Authorization Team

IF THE PATIENT HAS INSURANCE OTHER THAN MEDICARE OR TRADITIONAL OHIO MEDICAID PRECERTIFICATION IS REQUIRED.

PLEASE OBTAIN PRECERTIFICATION AND INCLUDE AUTHORIZATION BELOW:
Precertification
Authorization #:_____Date range: _____ # of infusions: _____

☐ No precertification necessary Name of person filling out this section: _____

If no precert required, list name of whom you spoke with at insurance company and on what date

Name: _____Company: _____Date: _____