## **Texas Centers for Infectious Disease Associates Pharmacy** FORT WORTH / 1025 College Ave., Fort Worth, TX 76104

Phone: 817-336-1640 Fax: 817-336-1643

DALLAS / 3410 Worth St., Ste. 780, Dallas TX 75246



Prescriber name:	Patient Information						Prescriber Information							
Address:   NPI   License:	Patient name:						Prescriber name:							
City: State: Zip:   Address:   City: State: Zip:   State: Zip: Zip: Zip: Zip: Zip: Zip: Zip: Zip	DOB: SSN:						DEA:							
Phone #:   City: State: Zip:	Address:						NPI License:							
Insurance Information: Complete entirely and fax front and back of patient's insurance card   Primary Insurance   Subscriber   ID:   Name of insurer:   Phone:	City: State: Zip:						Address:							
Insurance Information: Complete entirely and fax front and back of patient's insurance card Primary Insurance Subscriber ID: Name of insurer: Phone:  Secondary Insurance Subscriber ID: Name of insurer: Phone:  Prescription card: Name of insurer: ID: BIN: PCN: Group:  ICD 10 and Diagnosis: ICD 10: J45.50 Severe persistent asthma, uncomplicated J45.51 Severe persistent asthma with acute exacerbation Eosinophil count:cells/pt Date of test:	Phone #:						City: State: Zip:							
Primary Insurance   Subscriber   ID:   Name of insurer:   Phone:	Gender: □Male □Female □Other						Phone: Fax:							
Primary Insurance   Subscriber   ID:   Name of insurer:   Phone:	Insurance Information: Complete entirely and fax front and back of patient's insurance card													
Prescription card: Name of insurer: ID: BIN: PCN: Group:    ICD 10 and Diagnosis:   Patient History										Phone:				
ICD 10 and Diagnosis:   Patient History   Weight   Date of test:   Drug   Dose   Directions   Refills	Secondary Insurance		Subscriber	ID:			Name of insurer:			Phone:				
ICD 10:	Prescription card:		Name of insurer:		ID:	d		BIN:		PCN:	Group:			
ICD 10:														
ICD 10:	ICD 10 and Diagnosis:							tient Histor	rv		<u> </u>			
J45.51 Severe persistent asthma with acute exacerbation   CM			reistant asthma uncom	nlicate	d				_	G □I B	Height	ΠIN		
Eosinophil count: cells/pt Date of test:    Other ICD10: Number of asthma exacerbations (requiring the use of systemic corticosteroids and/or hospitalization) in the last 12 months: Droy	· · · · · · · · · · · · · · · · · · ·						vv	eigiit	шг		_			
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Drug   Dose   Directions   Refills														
Drug   Dose   Directions   Refills     Drug   Dose   Drug   Dose   Drug   Drug     Drug   Dose   Drug   Drug   Drug     Drug   Dose   Drug   Drug   Drug     Drug   Dose   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug														
Drug   Dose   Directions   Refills     Drug   Dose   Drug   Dose   Drug   Drug     Drug   Dose   Drug   Drug   Drug     Drug   Dose   Drug   Drug   Drug     Drug   Dose   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug   Drug     Drug														
MEDICATION    Nucala	Provider Orders:			1				51 1				7 7 711		
MEDICATION    Succession   Succ		Drug	Dose			Directions Refills								
Fasenra	MEDICATION	☐ Nucala	□ 100mg	□ 10	Omg every 4	4 weeks	weeks							
Fasenra														
Maintenance dose: 30mg SQ every 8 weeks			□ 30mg	duction do	dose: 30mg SQ every 4 weeks X first 3 doses									
Baseline labs on admission and then drawn weekly while on therapy    CBC with differential   CMP   CRP Quant   ESR   CK     other:    Nursing: Evaluate and teach patient administration of IV medication, provide IV-line dressing change weekly and PRN, use SASH flushing protocol: S- Saline 10ml, A- administration medication, S- saline 10ml, H-Heparin 5ml (100units/ml). When on more than one dose per day patient to alternate lumens for administration    Prescriber Authorization: I authorize this pharmacy and its representative to act as my agent to secure coverage, dose IV antibiotics based on labs, provide supplies necessary for infusion and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.		☐ Fasenra				dose: 30ma SO every 8 weeks								
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Prescriber signature: Date:														
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