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

Patient Information			Prescriber Information	
Patient name:			Prescriber name:	
DOB:	SSN:		DEA:	
Address:			NPI	License:
City:	State:	Zip:	Address:	
Phone #:			City:	State: Zip:
Gender: ☐Male ☐Female ☐Other			Phone:	Fax:

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:	Patient History	
ICD 10: ☐ J4S.50 Severe persistent asthma, uncomplicated ☐ J4S.51 Severe persistent asthma with acute exacerbation 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: _____	Weight ☐KG ☐LB	Height ☐IN ☐CM
	☐NKDA ☐Allergies:	

Provider Orders:				
	Drug	Dose	Directions	Refills
MEDICATION	☐ Nucala	☐ 100mg	☐ 100mg every 4 weeks	
	☐ Fasenra	☐ 30mg	☐ Induction dose: 30mg SQ every 4 weeks X first 3 doses ☐ Maintenance dose: 30mg SQ every 8 weeks	

LABS	
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.

Prescriber signature: _____ Date: _____