Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Specialty Order Form

Patient: _____	Ordering Provider: _____
DOB: _____ ☐ M ☐ F	NPI: _____
Height: _____ Weight: _____ lbs.	Practice: _____
Allergies: _____	Phone: _____
Diagnosis: _____	Fax: _____
ICD-10 Code(s): _____	Contact Name: _____

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s): _____

_____

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s): _____

☐ **NUCALA (MEPOLIZUMAB)** _____ mg Nucala by SubQ injection every 4 weeks

☐ **XOLAIR (OMALIZUMAB)** _____ mg Xolair by SubQ injection every _____ weeks

Physician's Signature: _____ **Date:** _____

Fax completed form to **(503) 540-3105**

Questions? Call us at **(503) 540-9999**