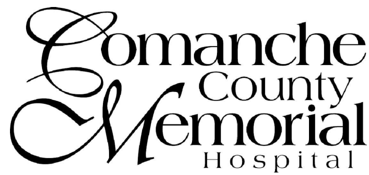

Outpatient Infusion Center
Nucala Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: M F

Patient Address: Email: Insurance:

Additional Information Needed

- Fax front/back of insurance card
- Fax patient demographics
- Fax clinical/progress notes
- Fax current medication list
- Fax labs
- Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- J45.5 Severe Persistent Asthma
- J45.50 Severe Persistent Asthma, uncomplicated
- J45.51 Severe Persistent Asthma with Acute Exacerbation
- J45.52 Severe Persistent Asthma with Status Asthmaticus
- J82 Pulmonary Eosinophilla, Not elsewhere classified
- M30.1 Polyarteritis with lung involvement (Churg-Strauss)
- Other: DX: ____________________

Clinical Information:

New Therapy Induction   Therapy Change   Therapy Continuation

Patient Weight:________ lbs/ ________ kg   Patient Height: ________ in/_______ cm

Allergies:____________________

Therapies Tried and Failed: ____________________

TB Test: Date: __________ Results: ______________   Hep B Test: Date:__________ Results:__________

Has the patient had a positive skin test to perennial aeroallergen? Yes or No Test Date:________ Results:__________

Has the patient had a positive RAST test? Yes or No   Test Date: __________ Results:__________

Has the patient pre-treatment IgE serum? Yes or No   Test Date:__________ Level: __________

Does the patient have venous access? Yes or No   If yes, What type? __________

If No, initiate IV access.

Lab Orders

CBC w/o diff   CMP   ESR   CRP   Total IgE

Other: ____________________

Lab Orders to be done by

Referring Provider

Prescription Information

	Dose	Frequency
☐ Nucala	Dose: 40mg (ages 6 to 11 years) Dose: 100mg Dose: 300mg	every 4 weeks

Misc Orders

☐ ____________________

☐ ____________________

PICC/Midline/CAD dressing to be changed every 7 days

Flushes

- 10mL NS Flush Syringe PRN
- Heparin 500units/5mL Flush Syringe PRN
- 50ml NS Bag PRN
- 250ml NS Bag PRN

Standing Orders for Adverse Reaction

- Stop infusion and initiate NS bolus
- Notify Supervising physician and ordering provider
- Solu-Cortef 100mg SIVP signs of adverse reaction
- Benadryl 25 mg SIVP for hives or bronchial inflammation
- Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
- Oxygen 2-5L nasal cannula
- Albuterol 2.5mg inhaled PRN to chest tightness
- Other: ____________________

Prescriber Information

Physician Name: ____________________   Official Contact Name: ____________________

Contact #: ____________________   Fax Number: ____________________

Address: ____________________   City/State/Zip: ____________________

NPI#: ____________ DEA#: ____________   State License #: ____________________

Physician's Signature   Date   Time