

## Outpatient Infusion Center Nucala Order

Please fax form to: 580-585-5472

Patient Name: DOB: Phone: Gender: M F Patient Address: Email: Insurance:  Additional Information Neodod Fax front/back of insurance card	Patient Information			
Additional Information Needed   Fax forniblack of insurance card   Fax clinical/progress notes   Fax labs   Fax TB and Hep B results     Fax patient demographics   Fax current medication list   Fax TB and Hep B results     Fax patient demographics   Fax TB and Hep B results     Fax patient demographics   Fax TB and Hep B results     Fax Labs     Fax TB and Hep B results     Fax TB and Hep B		DOB.	Phone:	Gender: M F
Additional Information Needed	Tation Name.	DOB.	T Hone.	Gender. W
Additional Information Needed	Patient Address:	Email:	la a compana a co	
Fax front/back of insurance card   Fax clinical/progress notes   Fax labs   Fax tabs	ratient Address.	Email.	insurance:	
Fax front/back of insurance card   Fax clinical/progress notes   Fax labs   Fax tabs	Additional Information Needed			
Fax patient demographics		Fay clinical/progress no	ntes 🔲 Favilah	ne .
Diagnosis and Clinical Information			<b>=</b>	
Just 5 Severe Persistent Asthma   Just 5 Severe Persistent Asthma   Just 5 Severe Persistent Asthma   Just 5 Severe Persistent Asthma with Acute Exacerbation   Just 5 Severe Persistent Asthma with Status Asthmaticus   Just 5 Severe Persistent Asthma with Acute Exacerbation   Just 5 Severe Persistent Ast				
J.45.50 Severe Persistent Asthma, uncomplicated J.45.51 Severe Persistent Asthma with Acute Exacerbation J.45.52 Severe Persistent Asthma with Nature Exacerbation J.45.52 Severe Persistent Asthma with Status Asthmaticus J.45.52 Severe Persistent Asthma with Acute Exacerbation J.45.52 Severe Persistent Asthma with Status Asthmaticus J.45.52 Severe Persistent Churg-Turation J.45.52 Severe Persistent Hasth Persistent Asthma with Institute Churg-Turation J.45.52 Severe Persistent Hasth Persistent Asthma with Institute J.45.52 Severe Persistent Hasth Persistent Persistent Level:				
J45.51 Severe Persistent Asthma with Acute Exacerbation   J45.52 Severe Persistent Asthma with Status Asthmaticus   Jas Pulmonary Eosinophilla, Not elsewhere classified   M30.1 Polyarteritis with lung involvement (Churg-Strauss)   Other: DX:   Clinical Information:   New Therapy Induction   Patient Weight:   Ibs/   kg   Patient Height:   in/   cm   Therapy Continuation   Patient Weight:   Ibs/   kg   Patient Height:   in/   cm   Therapy Continuation   Patient Weight:   Ibs/   kg   Patient Height:   in/   cm   Therapy Continuation   Patient Weight:   Ibs/   kg   Patient Height:   in/   cm   Therapy Continuation   Patient Weight:   Ibs/   kg   Patient Height:   in/   cm   Therapy Continuation   Patient May 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 had a positive RAST test? Yes or No Test Date:   Results:   Has the patient have venous access? Yes or No Test Date:   Results:   Level:				
J.45.62 Severe Persistent Ashma with Status Ashmaticus J.82 Putmonary Eosinophilla, Not elsewhere classified   M30.1 Polyartentis with lung involvement (Churg-Strauss)   Other: DX:				
Ja2 Pulmonary Eosinophilla, Not elsewhere classified   M30.1 Polyarteritis with lung involvement (Churg-Strauss)   Other: DX:   Clinical Information:   New Therapy Induction   Patient Weight:   Ibs/   kg   Patient Height:   in/   cm   Allergies:   Therapies Tried and Failed:   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:   Results:   Has the patient pre-treatment IgE serum? Yes or No Test Date:   Results:   Test Date:				
M30.1 Polyariertits with lung involvement (Churg-Strauss)   Other: DX:				
Other: DX:   Chilacal Information:				
New Therapy Induction		nurg-Strauss)		
New Therapy Induction				
Patient Weight:   Ibs/   kg		Therapy Change	□Thera	ny Continuation
Allergies: Therapies Tried and Failed: Therapies Tried Date: Therapies Tried D	Patient Weight: lbs/ kg	Patient Height:	in/ cm	py Continuation
Therapies Tried and Failed:  TB 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 had a positive RAST test? Yes or No Test Date: Results: Has the patient had a positive RAST test? Yes or No Test Date: Results: Has the patient had a positive RAST test? Yes or No Test Date: Results: Has the patient had a positive RAST test? Yes or No Test Date: Results: Has the patient had a positive RAST test? Yes or No Test Date: Results: Has the patient had a positive RAST test? 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: Results: Has the patient pre-treatment IgE serum? Yes or No Test Date: Results: Has the patient pre-treatment IgE serum? Yes or No Test Date: Results: Has the patient pre-treatment IgE serum? Yes or No Test Date: Results: Has the patient pre-treatment IgE serum? Yes or No Test Date: Results: Has Date: Resu	Allergies:		,	
Hep B 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 Does the patient have venous access? Yes or No If No, initiate IV access.   Test Date:   Level:   Le	Therapies Tried and Failed:			
Has the patient had a positive Skiff lest? Yes or No Has the patient had a positive Skiff lest? Yes or No Has the patient pre-treatment IgE serum? Yes or No Does the patient have venous access? Yes or No If No, initiate IV access.  Lab Orders    CBC w/o diff   CMP   ESR   CRP   Total IgE   Total IgE   Cother:   Referring Provider	TB Test: Date:Results:	Hep B 7	Test: Date:	Results:
Does the patient have venous access? Yes or No If No, initiate IV access.  Lab Orders  CBC w/o diff	Has the patient had a positive skin test to p	erenniai aeroaliergen? Yes or i	No rest Date:	Results:
Does the patient have venous access? Yes or No If No, initiate IV access.  Lab Orders  CBC w/o diff	Has the patient had a positive RAST test?	es or No Test Date:		Results:
If No, initiate IV access.  Lab Orders				
Lab Orders to be done by  GBC w/o diff		or No If yes	s, vvnat type?	
CBC w/o diff				
Other:				Lab Orders to be done by
Prescription Information		∐ Total IgE		Deferring Provider
Nucala				Referring Provider
Misc Orders  Misc Orders  ✓ PICC/Midline/CAD dressing to be changed every 7 days  Flushes  ✓ 10mL NS Flush Syringe PRN  ✓ 40mL NS Bag PRN  ✓ 50ml NS Bag PRN  ✓ 250ml NS Bag PRN  ✓ Dotter Information  ✓ Oxygen 2-5L nasal cannula  ✓ Oxygen 2-5L nasal cannula  ✓ Oxygen 2-5L nasal cannula  ✓ Other:  ✓ Describer Information  ✓ Other:  ✓ Prescriber Information  Official Contact Name:  Contact #:  Address:  City/State/Zip:  NP#:  DEA#:  State License #:		Dece: 40mg (eggs 6 to 11 w	ooro) Fraguerous I	over A weeks
Misc Orders			ears) Frequency.	every 4 weeks
Misc Orders	-			
Flushes  ✓ 10mL NS Flush Syringe PRN  ✓ heparin 500units/5mL Flush Syringe PRN  ✓ 50ml NS Bag PRN  ✓ 250ml NS Bag PRN  ✓ 250ml NS Bag PRN  ✓ 30ml NS Bag PRN  ✓ 250ml NS Bag PRN  ✓ 30ml NS Bag PRN  ✓ 30m	Misc Orders			
Flushes    10mL NS Flush Syringe PRN   Heparin 500units/5mL Flush Syringe PRN   50ml NS Bag PRN   250ml NS B		✓ PICC	/Midline/CAD dressing to	be changed every 7 days
✓ 10mL NS Flush Syringe PRN     ✓ Heparin 500units/5mL Flush Syringe PRN     ✓ 50ml NS Bag PRN     ✓ 250ml Negler     ✓ 250m	<del> </del>			in a constant of the second of
Heparin 500units/5mL Flush Syringe PRN	L		NS Flush Syringe 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  Physician Name: Contact #: Address: DEA#:  State License #:  Standing Orders for Adverse Reaction Epi 1:1000 1mL IM, IV or SQ for anaphylaxis Oxygen 2-5L nasal cannula Oxygen				
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  Physician Name: Contact #: Address: DEA#:  State License #:  State L			NS Rag PRN	yinige i rav
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  Prescriber Information  Physician Name:  Contact #:  Address:  NPI#:  DEA#:  State License #:			_	
✓ Stop infusion and initiate NS bolus ✓ Epi 1:1000 1mL IM, IV or SQ for anaphylaxis   ✓ Notify Supervising physician and ordering provider ✓ Oxygen 2-5L nasal cannula   ✓ Solu-Cortef 100mg SIVP signs of adverse reaction ✓ Albuterol 2.5mg inhaled PRN to chest tightness   ✓ Benadryl 25 mg SIVP for hives or bronchial inflammation Other:    Prescriber Information  Physician Name:  Contact #:  Fax Number:  Cotty/State/Zip:  NPI#:  DEA#:  State License #:  State License #:  Contact Name:  City/State/Zip:  State License #:  Contact Name:  City/State/Zip:  City/State/	Standing Orders for Advance Boarties	<b>▼</b> 230111	INO Day I KN	
Notify Supervising physician and ordering provider  Solu-Cortef 100mg SIVP signs of adverse reaction Benadryl 25 mg SIVP for hives or bronchial inflammation  Prescriber Information  Physician Name: Contact #: Address: City/State/Zip: NPI#: DEA#:  Oxygen 2-5L nasal cannula  Other: Other: Albuterol 2.5mg inhaled PRN to chest tightness  Other:  Other: Contact Name: Fax Number: City/State/Zip: State License #:				
Solu-Cortef 100mg SIVP signs of adverse reaction  Benadryl 25 mg SIVP for hives or bronchial inflammation  Prescriber Information  Physician Name:  Contact #:  Address:  DEA#:  DEA#:  Albuterol 2.5mg inhaled PRN to chest tightness  Official Contact Name:  Fax Number:  City/State/Zip:  State License #:	<b></b>	<del>_</del>		for anaphylaxis
Benadryl 25 mg SIVP for hives or bronchial inflammation  Prescriber Information  Physician Name: Official Contact Name:  Contact #: Fax Number:  Address: City/State/Zip:  NPI#: DEA#: State License #:	✓ Notify Supervising physician and ordering p	rovider	en 2-5L nasal cannula	
Prescriber Information  Physician Name: Official Contact Name:  Contact #: Fax Number:  Address: City/State/Zip:  NPI#: DEA#: State License #:	✓ Solu-Cortef 100mg SIVP signs of adverse reasons	eaction 📝 Albute	erol 2.5mg inhaled PRN	to chest tightness
Prescriber Information  Physician Name: Official Contact Name:  Contact #: Fax Number:  Address: City/State/Zip:  NPI#: DEA#: State License #:	Benadryl 25 mg SIVP for hives or bronchial	inflammation	·.	
Physician Name:         Official Contact Name:           Contact #:         Fax Number:           Address:         City/State/Zip:           NPI#:         DEA#:           State License #:				
Contact #:		Official Contac	t Name:	
Address:	-			
NPI#: DEA#: State License #:				
Physician's Signature Date Time	NPI#: DEA#:	State License	#:	
Physician's Signature Date Time				
Physician's Signature Date Time				



11/2021