

**Intravene – Nucala Injection Orders (rev 9/2016)**

**Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 2172**

**PATIENT INFORMATION**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Work Phone # \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs  
Drug Allergies \_\_\_\_\_  
 NKDA      Sex:  Male or  Female

**REFERRING PHYSICIAN INFORMATION**

Physician Name \_\_\_\_\_  
Physician Address \_\_\_\_\_  
Physician Phone(\_\_\_\_\_) \_\_\_\_\_  
Physician Fax(\_\_\_\_\_) \_\_\_\_\_  
NPI# \_\_\_\_\_ DEA# \_\_\_\_\_  
State License# \_\_\_\_\_

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and this form to 434-455-5531**

**DIAGNOSIS (ICD-10 required)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ ↑

**Other Asthma Therapies (tried and/or failed)**

**Name of Drug**

**Date Failed**

<input type="checkbox"/> Short-acting Beta-agonist	_____	_____
<input type="checkbox"/> Inhaled Corticosteroids (without LABA)	_____	_____
<input type="checkbox"/> Long-acting Beta-agonist (without ICS)	_____	_____
<input type="checkbox"/> Combination Therapy (LABA/ICS)	_____	_____
<input type="checkbox"/> Oral or Injectable Steroids	_____	_____
<input type="checkbox"/> Other (specify)	_____	_____

**LAB RESULTS:**

Eosinophil levels: \_\_\_\_\_ cells/ul      Test Date: \_\_\_\_\_  
Allergies: \_\_\_\_\_      Comorbidities: \_\_\_\_\_

**PRESCRIPTION:**

**Prescription Type:**     Naïve patient     Restart     Continue therapy

**Dispense NUCALA 100MG Subcutaneously, every 4 weeks**

**Duration:**     1 year     6 months     3 months     other \_\_\_\_\_

**Signature, prescribing MD \_\_\_\_\_      Date \_\_\_\_\_**

**Anaphylactic meds available at the bedside:**

Epinephrine 1:1000 1mg ampule. Administer 0.5ml (0.5mg) by SQ injection upon order of MD  
Hydrocortisone 100mg vial. Administer 100mg IV push upon order of MD  
Diphenhydramine 50mg vial. Administer 50mg IV push upon order of MD

**VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL**