Intravene – Nucala Injection Orders- for EGPA/ HES (rev 9/2022)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 3001

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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DIAGNOSIS (ICD-10 required)

☐ _____ _____
☐ _____ _____
☐ _____ _____

Has Patient had HES for ≥ 6 months without and identifiable non-hematologic secondary cause _____Yes _____ No

LAB RESULTS:

Eosinophil levels:_____cells/ul Test Date:_____
Allergies:_____ Comorbidities:_____

PRESCRIPTION:

Prescription Type: □ Naïve patient □ Restart □ Continue therapy

Dispense NUCALA 300MG Subcutaneously, every 4 weeks
Duration: □ 1 year □ 6 months □ 3 months □ other

ANAPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD _____ Date _____