OKLAHOMA INFUSION SERVICES

Nucala Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card
☐ Fax clinical/progress notes
☐ Fax labs
☐ Fax patient demographics
☐ Fax current medication list
☐ 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 Eosinophilia, not Elsewhere Classified
☐ M30.1 Polyarteritis with Lung Involvement [Churg-Strauss]
☐ Other: Code: __________ Description: ____

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 patient had positive skin test to perennial aeroallergen? ☐ Yes ☐ No Test Date: __________ Results: __________________
☐ Has patient had positive RAST test? ☐ Yes ☐ No Test Date: __________ Results: ______________________________________
☐ Has patient had pre-treatment IgE serum? ☐ Yes ☐ No Test Date: __________ Level: ______________________________________

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ Total IgE
☐ Other: ____________________________________

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

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

Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP
☐ Benadryl 25mg PO PRN
☒ Tylenol tablet 500-1000mg PO PRN
☐ Other: ____

Standing Orders for Adverse Reactions

☒ 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 for chest tightness
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☐ Other: ____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

____ ________________________

Prescriber's Signature: **Date:**

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

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