NPI#_____
DEA#_____

FAX ORDERS: 702-697-2107

LifeCare

NUCALA infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Severe Allergic Asthma with Eosinophilic Phenotype > 12
- ☐ _____ yro Adult Eosinophilic Granulomatosis with Polyangiitis
- ☐ _____ (EGPA) _____
  (other)

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

NUCALA ORDERS

DOSAGE

- ◉ 100mg SQ, every 4 weeks
- ○ 300mg SQ as separate 100mg injections, every 4 weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____

*Address:*_____ _____