Heartland Infusion Pharmacy

Phone: (865) 862 - 4557 www.heartlandinfusion.com Fax: (865) 862 – 4556
Alt. Fax: (865) 867 - 7081

# Nucala Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

**Referral Status:** ☐ New referral ☐ Dose or frequency change ☐ Order Renewal

## PATIENT INFORMATION

Name:

Home Phone: Cell Phone:

Email: Last four Social Security number

DOB: Height: Weight:

Allergies:

ICD-10 Diagnosis Code: Years with Disease:

TB Test (Circle One): Skin Quantiferon Chest Xray Result: Date:

## LABORATORY ORDERS

| | | | |
|---|---|---|---|
| ☐ CBC w/ Diff | ☐ each infusion | ☐ Other | |
| ☐ CRP | ☐ each infusion | ☐ Other | |
| ☐ CMP | ☐ each infusion | ☐ Other | |
| ☐ ESR | ☐ each infusion | ☐ Other | |
| ☐ Hepatic Panel | ☐ each infusion | ☐ Other | |
| ☐ Renal Panel | ☐ each infusion | ☐ Other | |
| ☐ Quantiferon TB (annually) | | Due: | |

☐ Other: _____

## Therapy Orders

☐ Administer 100 mg Nucala (mepolizumab) SQ every four weeks **OR** (specify):

_____

☐ Nursing per Heartland Nursing Procedures (incl reaction management)

☐ **Pre-Medications** ☐ No routine pre-medications required

☐ Tylenol (acetaminophen) _____ mg PO ☐ Zyrtec (cetirizine) 10 mg PO

☐ Solu-Medrol (methylprednisolone) _____mg IV ☐ Claritin (loratadine) 10 mg PO

☐ Benadryl (diphenhydramine) _____mg ☐ PO ☐ IV

☐ Other: _____

## PHYSICIAN INFORMATION

Physician's Name:

License #: NPI#: DEA#:

Address:

City: State: Zip:

Office Contact: Email:

Office Phone: Office Fax:

Physician Signature: _____ Date: _____

Patient is being referred to: ☐ Knoxville ☐ Morristown ☐ Kingsport