



Nucala Order Form

Select patient referral location: ☐ Akron ☐ Blue Ash ☐ Cleveland ☐ Columbus ☐ Crestview Hills ☐ Springfield ☐ West Cincinnati
☐ Other _____

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

- ☐ Severe Asthma (_____) ☐ Allergic Asthma (_____) ☐ Eosinophilic Asthma (_____) ☐ CIU (_____)
☐ ICD 10 (_____) ☐ Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

NUCALA

- ☐ Administer 100mg SubQ every 4 weeks, **OR**
☐ Administer _____

☐ Vital signs per HI Protocol
☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone _____ mg PO
☐ Other: _____

POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Prednisone _____ mg PO
☐ Other: _____

6. LABS

- | | | |
|--|--|---|
| <input type="checkbox"/> CBC w/Diff | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CRP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> ESR | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Hepatic Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Renal Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____ | | |
| <input type="checkbox"/> Other (specify): _____ | | |

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE