

RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Nucala Referral Order Form

Patient Information

| | |
|------------------|-----------------|
| Patient Name: | Patient DOB: |
| Patient Phone #: | Sex of Patient: |

Provider Information

| | |
|-------------------------|--------------------------------|
| Ordering Provider Name: | NPI # of Prescribing Provider: |
| Office Contact Name: | Office Phone #: |
| Office Contact Fax #: | Office Contact Email: |

Nucala Medication Orders

| | |
|---|--|
| Dosage <ul style="list-style-type: none">• ____ 100mg subcutaneously once every 4 weeks• ____ 300mg subcutaneously once every 4 weeks• ____ Other _____ | |
| Patient Weight: ____ Lbs or ____ Kg | |
| Diagnosis with ICD 10 code (REQUIRED) <ul style="list-style-type: none">• Diagnosis: ____ Asthma, severe eosinophilic ____ Eosinophilic granulomatosis with polyangiitis• ____ Other _____• ICD 10 code _____ | |
| Pre-Medication <ul style="list-style-type: none">• Tylenol ____ mg • Benadryl ____ mg __ IV or __ PO• Solumedrol IV Push ____ mg • Other _____ | Refills <ul style="list-style-type: none">• Zero ____ • Treatments for 1 year _____• Other _____ |

Required Documentation

| | | |
|---|---|--|
| <input type="checkbox"/> Insurance Cards (Front and Back) | <input type="checkbox"/> Patient Demographics | <input type="checkbox"/> Recent Progress Notes |
| Special Instructions/Notes | | |

Prescribing Provider Signature

Date of Signature

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