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Nucala Protocol and Consent

1. **Please be aware that you are responsible for your Nucala refills and medication being at the office that you wish to receive your injections in. It is your responsibility to call your pharmacy company for refills when necessary and to notify us if we need to contact the insurance company about refills/approvals. Please ask the nurse for list of pharmacies.**
2. Your wait times after your injections will be determined by your physician.
3. An office visit with the physician you see in our practice is required every 3-4 months to evaluate how your injections are going. Your Nucala injection should be scheduled during our injection hours, however it should not be scheduled at peak hours in the evening or on Tuesday afternoons in Skillman.
4. As with all injections you cannot be given an injection at the time of illness or fever. Please call the office to reschedule your appointment.

CONSENT FOR ADMINISTRATION OF IMMUNOTHERAPY

Authorization of Treatment

I have read the information in this consent form and in the patient information sheet provided to me and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of Nucala therapy, and these questions have been answered to my satisfaction. I understand that precautions consistent with the best medical practice will be carried out to protect me from adverse reactions to this therapy. I do hereby give consent for the patient designated below to be given the therapy (Nucala injections) over an extended period of time and at specified intervals, as prescribed by Princeton Allergy and Asthma. I further hereby give authorization and consent for treatment, from Princeton Allergy and Asthma and the staff, of any reactions that may occur as a result of the injection.

Before receiving Nucala, please tell Princeton Allergy about all of your medical conditions, including if you:

- Have a parasitic (helminth) infection
- Have not had chickenpox (varicella) or the chickenpox vaccine
- Are taking oral or inhaled corticosteroid medicines. Do not stop taking your corticosteroid medicines unless instructed by your physician. This may cause other symptoms that were controlled by the corticosteroid medicine to come back.
- Are pregnant or plan to become pregnant. It is not known if NUCALA may harm your unborn baby.
- Are breastfeeding or plan to breastfeed? You and your physician should decide if you will use NUCALA and breastfeed. You should not do both without talking with your physician first.

- Tell your physician about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.
- Do not stop taking your other asthma medicines unless instructed to do so by your physician.

NUCALA can cause serious side effects, including:

- Allergic (hypersensitivity) reactions. Serious allergic reactions can happen after you get your NUCALA injection. Allergic reactions can sometimes happen hours or days after you get a dose of NUCALA. Tell your healthcare provider or get emergency help right away if you have any of the following symptoms of an allergic reaction:
  - Swelling of your face, mouth, and tongue
  - Fainting, dizziness, feeling lightheaded (low blood pressure)
  - Hives
  - Breathing problems
  - Rash
- Herpes zoster infections that can cause shingles have happened in people who received NUCALA

The most common side effects of NUCALA include: headache, injection site reactions (pain, redness, swelling, itching or a burning feeling at the injection site), back pain, and weakness (fatigue).

Additional side effects may be viewed online.

Please be sure to verify that we have received your medication 2-3 days prior to your Nucala appointment. If we have not yet received it, please contact your pharmacy.

Please be aware that you will be charged for a Nurse Visit and administration of injection at each visit. You will be responsible for any copays, deductibles and coinsurance.

Printed Name of Patient: ____ Date: _____________

Patient/Parent Signature: ____ Date: _____________

Witness: ____ Date: _____________

FOR OFFICE USE ONLY:

I certify that I have counseled this patient and/or authorized legal guardian concerning the information in this Consent for therapy and that it appears to me that the signee understands the nature, risks, and benefits of the proposed treatment plan.

Physician: ____ Date: ____________