



**AYSA**

THERAPEUTICS INFUSION

# NUCALA (MEPOLIZUMAB) ORDER FORM

**P: 470.395.6076 | F: 470.745.0716**

**PATIENT INFORMATION**

*Demographics attached*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)**

**MEDICAL INFORMATION**

- Diagnosis:  Severe Asthma with Eosinophilic phenotype ICD-10 Code: \_\_\_\_\_
- Eosinophilic Granulomatosis with Polyangiitis (EGPA) ICD-10 Code: \_\_\_\_\_
- Hypereosinophilic Syndrome (HES) ICD-10 Code: \_\_\_\_\_
- Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) ICD-10 Code: \_\_\_\_\_

Patient Weight: \_\_\_\_\_ lbs.

Allergies: \_\_\_\_\_

- Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached
- CBC w/diff attached (required for Asthma and HES Diagnosis)

**Labs:** Required labs to be drawn by:  Infusion Clinic  Referring Physician

**Lab Orders:** \_\_\_\_\_

**NUCALA ORDERS**

**Eosinophilic Asthma or CRSwNP Dosing:**

Nucala 100mg subcutaneously every 4 weeks

**EGPA or HES Dosing:**

Nucala 300mg subcutaneously every 4 weeks

**ADDITIONAL ORDERS/COMMENTS**

**PHYSICIAN INFORMATION**

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: \_\_\_\_\_ Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

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