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: _____