

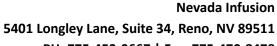


Nucala Order Form

Patient Na	me:		DOB:	
City:	State:	Zip:	Email:	
			Allergies:	
Several Severa	S: ere persistent asthma, und ere persistent asthma with -10: J45.51 inophilic Granulomatosis v -10: M30.1	n acute exacerbation	☐ Eosinophilic Asthma (ICD-10 code: J82☐ Chronic Rhinosinusitis with Nasal Poly	2.83) vps (CRSwNP)
☐ Nuc	R NUCALA (MEPOLIZUN cala 100mg subcutaneo cala 300mg subcutaneo	usly every 4 weeks x	•	
PRE-MEDIO	☐ Acetaminophen 650☐ Diphenhydramine 2☐ Hydrocortisone 100	5mg PO or IV or Zyrt mg IV or Methylpred	_	
✓ Nev	INISTER IF NEEDED FOR vada Infusion Hypersen ner:	sitivity Reaction Ord	er Set	
FLUSHING:	eripheral IV, Port, Midlin 10 mls NS pre/post inf Per Nevada Infusion		nl for port – 100 units/ml	
LABS ORDE	ERS:		Fax results to:	
	INFORMATION:		NPI:	
Physician S	lame: iignature:		NPI: Date:	
			e: Email:	

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

^{**}Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **





PH: 775-453-0667 | Fax: 775-470-8478

Patient Name: DOB:
Please Include Required Documentation for Expedited Order Processing & Insurance Approval:
☐ Signed provider orders (page 1)
☐ Patient demographic and insurance information
☐ Patient's current medication list
☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
☐ Supporting documentation to include past tried and/or failed therapies
\square Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or
contraindications to conventional therapy
\square Please indicate any tried and failed therapies (if applicable):
☐ Corticosteroids ☐ Long-acting beta 2 agonist ☐ Long-acting muscarinic antagonist ☐ Immunosuppressants (EGPA)
\square Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? \square Yes OR \square No
\Box Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120 (asthma)? \Box Yes OR \Box No
☐ Include labs and/or test results to support diagnosis
 □ Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks (asthma & EGPA) or ≥ 1000 cells/mcL within 4 weeks (HES) ? □ Yes OR □ No (please attach CBC) □ FEV1 score (if applicable):
☐ Is the patient or caregiver able to administer Nucala for self-administration?
☐ Yes OR ☐ No If no, please state reason:
□ Other medical necessity:

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