Nucala

Date: _____   Treatment Location: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg   Height: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____   Date: _____

Phone: _____   Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Diagnosis:

☐ Rhinosinusitis with nasal polyps ICD-10- J33.9   ☐ Polyarteritis with lung involvement [Churg-Strauss] M30.1
☐ Other pulmonary eosinophilia, not elsewhere classified J82.89 ☐ Eosinophilic asthma J82.83
☐ Acute eosinophilic pneumonia J82.82 ☐ Eosinophilic pneumonia, NOS J82.81 ☐ Nasal polyp, unspecified J33.9
☐ Severe persistent asthma, uncomplicated J45.50 ☐ Polypoid sinus degeneration J33.1
☐ Polyp of nasal cavity J33.0 ☐ Lymphocytic Variant Hypereosinophilic Syndrome [LHES] D72.111
☐ Hypereosinophilic syndrome [HES], unspecified D72.119 ☐ Idiopathic hypereosinophilic syndrome [IHES] D72.110
☐ Other DX/ICD10:

Pre-meds: Not usually indicated

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

NUCALA DOSAGE

_____ **mg Subcutaneous every 4 weeks** Route: ☑ SQ

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders: ☐ CBC, Eosinophils   ☐ Other: _____

☐ Prior to first appointment   ☐ Other Frequency: _____

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.