

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
 - Medication List
 - History & Physical
 - Initial Requests: Eosinophil Count
 - Patient Demographics
 - Most Recent Labs
- Renewal Requests: Did the patient experience measurable evidence of improvement in disease activity and/or severity? Y N (provide documentation)

PRIMARY DIAGNOSIS

- J33.0 Nasal polyps
- J45.50 Severe persistent asthma, uncomplicated
- J45.41 Severe persistent asthma with (acute) exacerbation
- J82.83 Eosinophilic asthma
- M30.1 Eosinophilic granulomatosis with polyangiitis (EGPA)
- Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Nucala
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Nucala 100mg SubQ every 4 weeks (for asthma)
 - Nucala 300mg (three 100mg injections) SubQ every 4 weeks (for EGPA)
 - Other: _____
- First Dose: Y N Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date