

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

*PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS

- | | |
|---|---|
| <input type="checkbox"/> D72. _____ Hypereosinophilic Syndrome - HES | <input type="checkbox"/> J82.83 Eosinophilic Asthma |
| <input type="checkbox"/> J33. _____ Nasal Polyps | <input type="checkbox"/> M30.1 Polyarteritis with lung involvement (EGPA / Churg-Strauss) |
| <input type="checkbox"/> J44. _____ Chronic Obstructive Pulmonary Disease | |
| <input type="checkbox"/> J45. _____ Persistent Asthma | |

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Insurance Information | <input type="checkbox"/> List of Medications | <input type="checkbox"/> Tried & Failed Therapies | <input type="checkbox"/> Most Recent History & Physical |
| <input type="checkbox"/> Pulmonary Function Tests to support diagnosis (if applicable) | <input type="checkbox"/> Eosinophil Levels (if applicable) | | |

MEDICATION ORDER

*Please complete dose when selecting frequency

- Nucala®(mepolizumab) 100mg via subcutaneous injection every 4 weeks (Asthma, COPD & Nasal Polyps dosing)
- Nucala® (mepolizumab) 300mg via subcutaneous injection every 4 weeks (EGPA & HES dosing)
- Nucala® (mepolizumab) 40mg via subcutaneous injection every 4 weeks (age 6 to 11 dosing)

Provider Attestation of need for HCP administration

(may be required by insurance)

- _____
INITIALS Patient has experienced severe hypersensitivity reactions to Nucala within the past 6 months and requires administration and direct monitoring by a healthcare professional.
- _____
INITIALS Patient or caregiver are not competent or are physically unable to administer the Nucala formulation labeled for self-administration.
- _____
INITIALS Patient has history of uncontrolled disease and in the clinical opinion of the ordering provider, it is not advisable to try the self-administered formulation of Nucala.
- _____
INITIALS The circumstances and location for self-administration are not adequate for the potential treatment of anaphylaxis.
- _____
INITIALS Patient's weight is such that in the clinical opinion of the ordering provider, it is not advisable to try the self-administered formulation of Nucala.

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first injection and then for 15 minutes following each subsequent injection. Administer per protocol. In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN