

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F
 Ht: _____ Wt: _____ lbs kg Primary Language: _____
 Allergies: _____ Patient Preferred Location: _____

Diagnosis

Primary ICD 10 Code (Required)

D72.119 Hypereosinophilic Syndrome (HES)
 J33.9 Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
 J44.0-J44.9 Chronic Obstructive Pulmonary Disease (COPD)

J45.51 Severe Persistent Asthma, w/Acute Exacerbation
 M30.1 Eosinophilic Granulomatosis with Polyangitis (EGPA)
 J82.83 Eosinophilic Asthma

Other: _____

Patient Status

New to therapy
 Continuing therapy
 (date of last dose _____)

Medication Order

NUCALA (mepolizumab)

Dose (≥ 12 years old)

SubQ: Inject 100 mg every 4 weeks for one year
SubQ: Inject 300 mg every 4 weeks for one year (EPGA & HES dosing)

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments: _____

Required Clinical Documentation

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Is the patient on any other disease modifying therapy?

Yes No

If yes, please note therapy and last dose:

LAB RESULTS: Blood eosinophil level OR CBC with differential AND pulmonary function test prior to initiating therapy

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____