Sarah Bush Lincoln

**NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.**

## PATIENT INFORMATION

| Name: | DOB: |
|---|---|
| Allergies: | Date of Referral: |

## REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

## INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

## Diagnosis and ICD 10 CODE

☐ Severe Uncontrolled Asthma with Eosinophilic Phenotype — ICD 10 Code: J45.50

→ Does the patient have current blood eosinophil counts ≥ 150 cells/μL? ☐ YES ☐ NO

☐ Eosinophilic Granulomatosis with Polyangitis (EGPA) — ICD 10 Code: M30.1

→ Has the patient relapsed or been refractory to standard of care therapy, including oral steroids? ☐ YES ☐ NO

☐ Chronic Obstructive Pulmonary Disease — ICD 10 Code: J44.9

☐ Chronic Rhinosinusitis with Nasal Polyps — ICD 10 Code: J33.9

☐ Hypereosinophilic Syndrome — ICD 10 Code: D72.119

☐ Diagnosis: _____ — ICD 10 Code: _____

☐ Diagnosis: _____ — ICD 10 Code: _____

## REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ Pulmonary Function Tests (if asthma)
*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 year)

☐ Labs and Tests supporting primary diagnosis, including blood eosinophil counts (must be within 1 year)

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

## MEDICATION ORDERS

**Dosing Wt for Calculations** Ht: Wt: BMI:

☐ J2182 Nucala 40mg subQ every 4 weeks

☐ J2182 Nucala 100mg subQ every 4 weeks

☐ J2182 Nucala 300mg subQ every 4 weeks

**Duration** ☐ **X 6 months** ☐ **X 1 year** _____ **doses**

## ADDITIONAL ORDERS / INFORMATION

## PRESCRIBER INFORMATION

| Prescriber name: | | |
|---|---|---|
| Office Phone: | Office Fax: | Office Email: |
| Prescriber Signature: | | Date: Time: |

**All information contained in this order form is strictly confidential and will become part of the patient's medical record.**

Contact us with questions at: SBL Infusion Center
Ph. 217-258-4150
217-342-7500

Fax Completed Form and all documentation to: Fax 217-342-7499



**MEDICATION ORDERS - NUCALA (MEPOLIZUMAB)**

Clinic Scan to: Physician Orders