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:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

MEDICATION ORDERS - NUCALA (MEPOLIZUMAB)

Clinic Scan to: Physician Orders