Nucala® Provider Order Form

Please fax completed referral order form & all required documents to **281-295-4051**

AguaVivir
www.aguavivir.com

PATIENT DEMOGRAPHICS

Patient Name: ____________________ DOB: ______________ Phone: ______________

Address: ____________________ City/ST/Zip: ____________________

Allergies: ____________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: ________ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Severe Asthma (J45.50-J45.52), ICD10 __________

☐ Nasal Polyps (J33.0-J33.9), ICD10 __________

☐ Other: ____________________, ICD10 __________

☐ Eosinophilic Granulomatosis with Polyangiitis [EGPA], M30.1

☐ Hypereosinophilic Syndrome [HES] (D72.110-D72.119), ICD10 __________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Nucala® (mepolizumab)	☐ 40 mg ☐ 100 mg ☐ 300 mg	Inject SUBQ every 4 weeks x 1 year ☐ Observe patient for 1 hour after each dose

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: ____________________

Date of last treatment: ______________ Date of next treatment: ______________

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: ____________________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q ________ ☐ CMP q ________ ☐ CRP q ________

☐ ESR q ________ ☐ LFTs q ________ ☐ Other: ________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ____________________ Date: ______________

Physician Name: ______________ Provider NPI: ______________ Specialty: ______________

Address: ____________________ City/ST/Zip: ______________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ____________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ **See Attached Medical Records**

LAB AND TEST RESULTS for ASTHMA DIAGNOSIS (required)

☐ Pre-treatment serum eosinophil level

☐ Pre-treatment pulmonary function test

- ☐ FEV-1 <80% predicted
- ☐ FEV-1 reversibility ≥12% and 200mL after albuterol administration

☐ Other: ____________________

LAB AND TEST RESULTS for NASAL POLYPS (required)

☐ Diagnostic work-up (Attach report of imaging study):

- ☐ Nasal endoscopy ☐ Anterior rhinoscopy ☐ Sinus CT scan

☐ Pre-treatment IgE level

☐ Other: ____________________

LAB AND TEST RESULTS for EGPA and HES (required)

☐ Pre-treatment serum eosinophil level

☐ Other: ____________________

PRIOR FAILED THERAPIES

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________