BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

NUCALA (MEPOLIZUMAB) INJECTION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis:

☐ Severe persistent asthma, uncomplicated (ICD-10 code: J45.50)

☐ Severe persistent asthma with acute exacerbation (ICD-10 code: J45.51)

☐ Eosinophilic Granulomatosis with Polyangiitis (EGPA) (ICD-10 code: M30.1)

☐ Hypereosinophilic Syndrome (HES) (ICD-10 code: D72.11)

☐ Eosinophilic Asthma (ICD-10 code: J82.83)

☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (ICD-10 code: _____)

☐ Other: _____ (ICD-10 code: _____)

Patient Weight: _____ lbs. Allergies: _____

THERAPY ORDER

Severe Asthma or CRSwNP Dosing:

☐ Nucala 100mg subcutaneously every 4 weeks x 1 year

EGPA or HES Dosing:

☐ Nucala 300mg subcutaneously every 4 weeks x 1 year

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR NUCALA (MEPOLIZUMAB) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Please indicate any tried and failed therapies (if applicable):

- ☐ Corticosteroids _____
- ☐ Long acting beta 2 agonist _____
- ☐ Long acting muscarinic antagonist _____
- ☐ Immunosuppressants (EGPA) _____

☐ Does the patient have a history of 2 exacerbations requiring a course of oral/ systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? ☐ Yes ☐ No

☐ Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120 (asthma)? ☐ Yes ☐ No

☐ Include labs and/or test results to support diagnosis

☐ Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks (asthma & EGPA) or ≥ 1000 cells/mcL within 4 weeks (HES)? ☐ Yes ☐ No **(attach CBC)**

☐ FEV1 score (if applicable): _____

☐ Is the patient or caregiver able to administer Nucala for self-administration? ☐ Yes ☐ No

☐ Other medical necessity: _____

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance