INTRAMED Plus
infusion services

NUCALA®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis:
- _____ Severe persistent Asthma, uncomplicated — ICD-10 Code: J45.50 _____
- _____ Severe persistent Asthma with acute exacerbation — ICD-10 Code: D59.5 _____
- _____ Eosinophilic Granulomatosis with Polyangitis — ICD-10 Code: M30.1 _____
- _____ Other: — ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Including pulmonary function tests and CBC with diff
- Previous Drug Therapy History, including therapies trailed/failed and date of last administration: _____
- ❑ Xolair ❑ Cinqair ❑ Fasenra Date: _____
  Desired Washout Period: _____ weeks

Patient
Weight: _____ lbs.
Height: _____ in.

NUCALA® (mepolizumab)

4. Drug Order:

Nucala (mepolizumab) 100 mg

❑ **Eosinophilic Asthma:**
Nucala 100 mg subcutaneously every four weeks _____ # Refills (Recommend 5)

❑ **Eosinophilic Granulomatosis with Polyangitis:**
Nucala 300 mg subcutaneously every four weeks _____ # Refills (Recommend 5)

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 800.767.6337