



# NUCALA (MEPOLIZUMAB) INFUSION ORDERS

**P:** 877.365.5566 | **F:** 855.889.2946

**PATIENT INFORMATION:** Fax completed form, insurance information, and clinical documentation to 855.889.2946

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 Paragon Healthcare, Inc. 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 Paragon selecting site of care (if checked, please list site of care): \_\_\_\_\_

**PREFERRED LOCATION**

City: \_\_\_\_\_ State: \_\_\_\_\_

*View our locations here:*



PARAGONHEALTHCARE.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

**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  $\geq 150$  cells/mcL within the past 6 weeks (asthma & EGPA) or  $\geq 1000$  cells/mcL within 4 weeks (HES)?  Yes  No **(attach CBC)**
  - FEV1 score (if applicable): \_\_\_\_\_
- Is the patient or caregiver not competent or physically unable to administer the Nucala product for self-administration?  Yes  No
- Other medical necessity: \_\_\_\_\_

Paragon Healthcare 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 (855) 889-2946 or call (877) 365-5566 for assistance**