

PATIENT INFORMATION			
Name:			DOB:
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon <input type="checkbox"/> Effingham			
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.			
Diagnosis and ICD 10 CODE (See attached code listing)			
<input type="checkbox"/> Severe Uncontrolled Asthma with Eosinophilic Phenotype → Does the patient have current blood eosinophil counts \geq 150 cells/ μ L? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Eosinophilic Granulomatosis with Polyangitis (EGPA) → Has the patient relapsed or been refractory to standard of care therapy, including oral steroids? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Diagnosis: _____ <input type="checkbox"/> Diagnosis: _____		ICD 10 Code: J45.50 ICD 10 Code: M30.1 ICD 10 Code: _____ ICD 10 Code: _____	
REQUIRED DOCUMENTATION			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Pulmonary Function Tests (if asthma)		<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <input type="checkbox"/> Labs and Tests supporting primary diagnosis, including blood eosinophil counts <input type="checkbox"/> Pregnancy Test (if applicable)	
List Tried & Failed Therapies, including duration of treatment:			
1) 2) 3)			
MEDICATION ORDERS			
Dosing Wt for Calculations		Ht:	Wt:
Dosing for Severe Asthma with Eosinophilic Phenotype		<input type="checkbox"/> Nucala 100mg subQ every 4 weeks	
Dosing for EGPA		<input type="checkbox"/> Nucala 300mg subQ every 4 weeks	
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year _____ doses			
ADDITIONAL ORDERS			
PRESCRIBER INFORMATION			
Prescriber name:			
Office Phone:		Office Fax:	
Office Email:		Date:	
Prescriber Signature:		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

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☐ EFFINGHAM

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