

Prescriber Information											
Prescriber Name:					MD	DO	NP	PA	NPI:		
Office Contact:					Practice Name / Collaborating MD:						
Address:				City:			State:		Zip:		
Phone:			Fax:								
Patient Information • PLEASE SEND COPY OF INSURANCE CARD											
Patients Name:			Last 4 Digits of SS#:		DOB: / /		Sex: M F		Weight:	Height:	Diabetic? Y N
Office Contact:					Practice Name / Collaborating MD:						
Address:				City:			State:		Zip:		
Home Phone:			Work/Cell:		HIPPA Contact:			Emergency #:			
Interpreter Needed? Y N		Allergies: Y N If Yes, list allergies:									
Insurance Information											
Primary Insurance:			Policy ID:		Group #:		BIN:		PCN:		
Policyholder Name:					Policyholder DOB: / /						
Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES											
ICD-10/Diagnosis Code:		Pulmonary Eosinophilia (J82)		Moderate Persistent Asthma, uncomplicated (J45.40)		Severe Persistent Asthma, uncomplicated (J45.50)		Idiopathic Urticaria (L50.1)			
Atopic Dermatitis (L20.9)		Nasal Polyp (J33. _____)		Other:				FEV1: %			
Pre-treatment serum IgE: < 30 IU/mL ≥30-100 IU/mL > 100-200 IU/mL > 200-300 IU/mL > 300-400 IU/mL > 400-500 IU/mL > 500-600 IU/mL > 600-700 IU/mL											
Patient medical history includes: Positive RAST Positive skin test to perennial aeroallergen Asthma with eosinophilic phenotype Other:											
Current maintenance treatment (include dose and frequency):									Patient is a smoker or is exposed to smoke in the home: Y N		
Current exacerbation treatment (include dose and frequency):											
Prior Treatment? Y N (Provide Information Below)		BSA Affected (%):		Affected Areas: Palms Soles Head Neck Genitalia Other:							
Prior Therapy:				Reason for Discontinuation of Therapy:				Approx. Start Date: / /		Approx. End Date: / /	
Comorbidities:					Concomitant Medications:						
Prescription Information											
Medication		Quantity/Dose			Sig			Refills			
NUCALA® <i>*Pediatric Asthma (patients 6-11 years old)</i> Vial Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____		1x100mg			Inject 40mg subcutaneously once every 4 weeks						
NUCALA® <i>*Asthma (12 years and older) & CRSwNP (adults)</i> Autoinjector PFS Vial Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____		PFS: 1 carton (1x100mg/ml) Autoinjector: 1 carton (100mg/ml) Vial: 1x100mg			Inject 100mg subcutaneously once every 4 weeks						
NUCALA® <i>*HES (patients 12 years and older) and EGPA (adults)</i> Autoinjector PFS Vial Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____		PFS: 3 cartons (1x100mg/ml) Autoinjector: 3 cartons (100mg/ml) Vial: 3x100mg			Inject 300mg subcutaneously once every 4 weeks						
XOLAIR® PFS Vial Sterile water for injection (to be used with Xolair vials) Number of vials: _____ Refills: _____		PFS: Number of 75mg/0.5ml syringes: _____ PFS: Number of 150mg/ml syringes: _____ Number of 150mg vials: _____			Inject _____ mg SQ once every _____ weeks						
Other:											
Injection Training											
Patient received injection training			Prescriber's office to provide injection training			Meijer to coordinate injection training					
By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.											
Prescriber Signature				Date		Prescriber Signature			Date		

Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.