℞ meijer specialty pharmacy

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Allergy/Asthma

Nucala®, Xolair®

Prescriber Information

Ship Meds to: ◯ Patient's Home ◯ Prescriber's Office

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:		Practice Name / Supervising MD:	
Address:		City:	
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯Y ◯N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

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):

Current exacerbation treatment (include dose and frequency): | Patient is a smoker or is exposed to smoke in the home: ◯ Y ◯ N

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®** **Pediatric Asthma (patients 6-11 years old)* ◯ Vial ◯ Sterile water for injection (to be used with Nucala vials) Number of vials: _______ Refills: ______	◯ 1x100mg	◯ Inject 40mg subcutaneously once every 4 weeks	
◯ **NUCALA®** **Asthma (patients 12 years and older)* ◯ 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®** **HES (patients 12 years and older) and EGPA (adults)* ◯ 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:**			

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.