

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

Prescriber Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> 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: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> 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:		<input type="radio"/> Pulmonary Eosinophilia (J82) <input type="radio"/> Moderate Persistent Asthma, uncomplicated (J45.40) <input type="radio"/> Severe Persistent Asthma, uncomplicated (J45.50) <input type="radio"/> Idiopathic Urticaria (L50.1)				
<input type="radio"/> Atopic Dermatitis (L20.9) <input type="radio"/> Nasal Polyp (J33.____) <input type="radio"/> Other:						
FEV1: %	Pre-treatment serum IgE: <input type="radio"/> <30 IU/mL <input type="radio"/> ≥30-100 IU/mL <input type="radio"/> >100-200 IU/mL <input type="radio"/> >200-300 IU/mL <input type="radio"/> >300-400 IU/mL <input type="radio"/> >400-500 IU/mL <input type="radio"/> >500-600 IU/mL <input type="radio"/> >600-700 IU/mL					
Patient medical history includes: <input type="radio"/> Positive RAST <input type="radio"/> Positive skin test to perennial aeroallergen <input type="radio"/> Asthma with eosinophilic phenotype <input type="radio"/> 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: <input type="radio"/> Y <input type="radio"/> N		
Prior Treatment? <input type="radio"/> Y <input type="radio"/> N (Provide Information Below)		BSA affected (%):	Affected Areas: <input type="radio"/> Palms <input type="radio"/> Soles <input type="radio"/> Head <input type="radio"/> Neck <input type="radio"/> Genitalia <input type="radio"/> Other:			
Prior Therapy	Reason for Discontinuation of Therapy		Approx Start Date	Approx End Date		
Comorbidities:		Concomitant Medications:				

Prescription Information

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> NUCALA® *Pediatric Asthma (patients 6-11 years old) <input type="radio"/> Vial <input type="radio"/> Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____	<input type="radio"/> 1x100mg	<input type="radio"/> Inject 40mg subcutaneously once every 4 weeks	
<input type="radio"/> NUCALA® *Asthma (patients 12 years and older) <input type="radio"/> Autoinjector <input type="radio"/> PFS <input type="radio"/> Vial <input type="radio"/> Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____	<input type="radio"/> PFS: 1 carton (1x100mg/ml) <input type="radio"/> Autoinjector: 1 carton (100mg/ml) <input type="radio"/> Vial: 1x100mg	<input type="radio"/> Inject 100mg subcutaneously once every 4 weeks	
<input type="radio"/> NUCALA® *HES (patients 12 years and older) and EGPA (adults) <input type="radio"/> Autoinjector <input type="radio"/> PFS <input type="radio"/> Vial <input type="radio"/> Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____	<input type="radio"/> PFS: 3 cartons (1x100mg/ml) <input type="radio"/> Autoinjector: 3 cartons (100mg/ml) <input type="radio"/> Vial: 3x100mg	<input type="radio"/> Inject 300mg subcutaneously once every 4 weeks	
<input type="radio"/> XOLAIR® <input type="radio"/> PFS <input type="radio"/> Vial <input type="radio"/> Sterile water for injection (to be used with Xolair vials) Number of vials: _____ Refills: _____	<input type="radio"/> PFS: Number of 75mg/0.5ml syringes: _____ <input type="radio"/> PFS: Number of 150mg/ml syringes: _____ <input type="radio"/> Number of 150mg vials: _____	<input type="radio"/> Inject _____mg SQ once every _____ weeks	
<input type="radio"/> 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
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Substitution Permitted

Dispense as Written

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