

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
Address:		City:	State:		Zip:		
Home Phone:		Work/Cell:	HIPAA 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. _____)	Eosinophilic esophagitis (K20)	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
EBGLYSS™	QS for appropriate month of starter dose schedule	Starter Dose: Inject 500mg (two 250mg injections) SQ at week 0 and 2, then 250mg SQ every 2 weeks until week 16 or later (when adequate clinical response is achieved)	4 Refills
	1 carton (1x250mg/2ml) PEN	Maintenance Dose: Inject 250mg SQ every 4 weeks	
NUCALA® <i>*Pediatric Asthma (patients 6-11 years old)</i> Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____	1 carton (1x40mg/0.4ml)	Inject 40mg SQ once every 4 weeks	
NUCALA® <i>*Asthma (12 years and older) & CRSwNP (adults)</i> Pen PFS Vial Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____	1 carton (1x100mg/ml)	Inject 100mg SQ once every 4 weeks	
NUCALA® <i>*HES (patients 12 years and older) and EGPA (adults)</i> Pen PFS Vial Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____	3 cartons (3x100mg/ml)	Inject 300mg SQ once every 4 weeks	
RINVOQ™	15mg tablet (30 day supply) 30mg tablet (30 day supply)	Take 1 tablet by mouth daily	
XOLAIR® <i>*Pen only for use in ages 12+</i> PFS Vial Pen Sterile water for injection (to be used with Xolair vials) Number of vials: _____ Refills: _____	Number of 75mg/0.5ml pens/syringes: _____ Number of 150mg/ml pens/syringes: _____ Number of 300mg/2ml pens/syringes: _____ Number of 150mg vials: _____	Inject _____ mg SQ once every _____ weeks	

Injection Training

Patient received injection training	Prescriber's office to provide injection training	Meijer to coordinate injection training
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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

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