

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

| | | | | | | | | |
|-------------------------|--|-----------------------|--|----------------|----------|--------------|---------|---------------|
| Patient 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 | | BSA Affected (%): | Affected Areas: Palms Soles Head Neck Genitalia Other: | | | | | |
| Notes for Pharmacy: | | | | | | | | |

Prescription Information

| Medication | Quantity/Dose | Sig | Refills |
|---|--|---|---------|
| NUCALA® *Pediatric Asthma (patients 6-11 years old) | 1 carton (1x40mg/0.4ml) PFS | Inject 40mg SQ once every 4 weeks | |
| NUCALA® *Asthma (12 years and older) & CRSwNP (adults) 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® *HES (patients 12 years and older) and EGPA (adults) 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 | |
| RHAPSIDO® | 25mg tablet (60 tablets) | Take 1 tablet by mouth twice daily | |
| RINVOQ™ | 15mg tablet (30 day supply) 30mg tablet (30 day supply) | Take 1 tablet by mouth daily | |
| XOLAIR® *Pen only for use in ages 12+ 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 |
|-------------------------------------|---|---|

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.