

**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 <b>If Yes, list allergies:</b>							

**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
<b>NUCALA®</b> *Pediatric Asthma (patients 6-11 years old) Vial PFS Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____	<b>PFS:</b> 1 carton (1x40mg/0.4ml) <b>Vial:</b> 1x100mg	Inject 40mg subcutaneously once every 4 weeks	
<b>NUCALA®</b> *Asthma (12 years and older) & CRSwNP (adults) Autoinjector PFS Vial Sterile water for injection (to be used with Nucala vials) Number of vials: _____ Refills: _____	<b>PFS:</b> 1 carton (1x100mg/ml) <b>Autoinjector:</b> 1 carton (100mg/ml) <b>Vial:</b> 1x100mg	Inject 100mg subcutaneously once every 4 weeks	
<b>NUCALA®</b> *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: _____	<b>PFS:</b> 3 cartons (1x100mg/ml) <b>Autoinjector:</b> 3 cartons (100mg/ml) <b>Vial:</b> 3x100mg	Inject 300mg subcutaneously once every 4 weeks	
<b>RINVOQ™</b>	15mg tablet (30 day supply) 30mg tablet (30 day supply)	Take 1 tablet by mouth daily	
<b>XOLAIR®</b> 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	
<b>Other:</b>			

**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

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