

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Severe Uncontrolled Asthma with Eosinophilic Phenotype ICD 10 Code: J45.50 → Does the patient have current blood eosinophil counts \geq 150 cells/ μ L? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Eosinophilic Granulomatosis with Polyangitis (EGPA) ICD 10 Code: M30.1 → Has the patient relapsed or been refractory to standard of care therapy, including oral steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Other: _____ ICD 10 Code: _____		
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number <small>*Pt may be required to submit a pregnancy test prior to treatment</small>	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> labs and tests supporting primary diagnosis, including blood eosinophil counts <input type="checkbox"/> Pulmonary Function Tests (If Asthma)	
List of tried and failed therapies, including duration of treatment: 1) _____ 2) _____		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____		
Dosing for Severe Asthma with Eosinophilic Phenotype	<input type="checkbox"/> J2182 Nucala 100mg SubQ every 4 weeks	
Dosing for EGPA	<input type="checkbox"/> J2182 Nucala 300mg SubQ every 4 weeks	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
PREMEDICATIONS/ LAB ORDERS		
<input type="checkbox"/> Acetaminophen _____ mg PO PRN <input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Other: _____ Date: _____ <input type="checkbox"/> Other: _____		
ADDITIONAL ORDERS/INFORMATION		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – NUCALA (MEPOLIZUMAB)