REVITALIZE
INFUSION CENTER

Nucala®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

- ☐ Severe Allergic Asthma with eosinophilic phenotype ICD-10 Code: J82.83
- ☐ Eosinophilic Granulomatosis with Polyangiitis ICD-10 Code: M30.1
- ☐ Chronic rhinosinusitis with nasal polyps (CRSwNP) ICD-10 Code: J33.0
- ☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Include previously tried and failed therapies
- Relevant labs and tests

Height: _____

Weight: _____

Nucala (mepolizumab) Orders:

- ☐ 100 mg subcutaneously every 4 weeks for 12 months
- ☐ 300 mg subcutaneously (as separate 100 mg injections) every 4 weeks for 12 months

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus