

Infusion Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis:

- | | |
|---|---------------------|
| <input type="checkbox"/> Severe Allergic Asthma with eosinophilic phenotype | ICD-10 Code: J82.83 |
| <input type="checkbox"/> Eosinophilic Granulomatosis with Polyangiitis | ICD-10 Code: M30.1 |
| <input type="checkbox"/> Chronic rhinosinusitis with nasal polyps (CRSwNP) | ICD-10 Code: J33.0 |
| <input type="checkbox"/> 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 #:

Please fax the completed order form and all other requested information to: 601-714-1569

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



Revitalize



Revitalize Locations



InfusionPlus