

## *Nucala Request Form*

2301 Evesham Road, Building 800, Suite 115  
Voorhees, New Jersey 08043  
T. (866)497-0905  
F. (866)228-9798 Attn: Idyllic Infusion Coordinator

**Is this a Continuation of Care or a new start to the medication?**

- Continuation of Care (Provide documentation of last administration)  
 New Rx

<b>DATE:</b>	
<b>REFERRING PROVIDER INFORMATION</b>	
<b>Requesting Provider Name and NPI Tax ID#</b>	<b>Name: NPI: Tax ID#</b>
<b>Fax Number</b>	
<b>Practice Contact (Name/Phone number)</b>	
<b>Email of Contact</b>	
<p><i>We will gladly remind your patient to schedule routine follow-up visits with your office.</i></p> <p><b>Return to Referring Provider (frequency): EVERY_____ WKS / MOS</b></p>	
<b>PATIENT INFORMATION</b>	
<b>Patient Name</b>	
<b>Date of Birth</b>	/ /
<b>Height in ft/in: Weight in lbs:</b>	
<b>Insurance(s): include copies of front and back</b>	

<b>Preferred Treatment Location</b>	<input type="checkbox"/> Voorhees <input type="checkbox"/> Wall/Manasquan <input type="checkbox"/> Hamilton <input type="checkbox"/> Moorestown <input type="checkbox"/> Sewell <input type="checkbox"/> Galloway
<b>Primary Care Physician (Name / Phone Number)</b>	PCP Name: PCP Phone Number:

**Diagnosis:**

- D72.110 Idiopathic hypereosinophilic syndrome
- J33.0 Nasal cavity polyp
- D72.11 Lymphocytic Variant hypereosinophilic syndrome
- J33.1 Polypoid sinus degeneration
- J45.50 Severe persistent asthma, uncomplicated
- J82.81 Eosinophilic pneumonia, NOS
- J82.82 Acute eosinophilic pneumonia
- J82.83 Eosinophilic asthma
- J82.89 Other pulmonary eosinophilia
- M30.1 Polyarteritis w/ lung inv.

**For severe persistent asthma:**

- Is there evidence of reversibility?  **YES**  **NO**
- Is the patient symptomatic despite regular use of medium to high inhaled steroid **and** an additional controller (ie. long acting beta agonist)?  **YES**  **NO**
- Did the patient have 2 or more exacerbations in the past year requiring oral steroids?  **YES**  **NO**
- Was there an elevated peripheral blood eosinophil level of  $\geq 150$  cells/uL at baseline (within 6 weeks of initial dosing) **or** an elevated peripheral blood eosinophil level of  $\geq 300$  cells/uL in the prior 12 months?  **YES**  **NO**
- Is the patient currently being treated with omalizumab or other parenteral IL-5 antagonist?  **YES**  **NO**

**For EGPA:**

- Is there a blood eosinophil level of  $> 10\%$  **or** an absolute eosinophil count of  $>1000$  cells/mm<sup>3</sup>?  **YES**  **NO**
- Are the diagnostic criteria of EGPA present?  **YES**  **NO**
- Is the patient on stable doses of concomitant oral corticosteroid therapy for at least 4 weeks?  **YES**  **NO**
- What is the patient's baseline Birmingham Vasculitis Activity Score? \_\_\_\_\_ Attach details (if appl)

**For HES:**

- Is there a diagnosis of hypereosinophilic syndrome (HES)  $\geq$  6 months without identifiable non-hematologic secondary cause?  **YES**  **NO**
- How many HES flares within the past 12 months? \_\_\_\_\_
- Is there a blood eosinophil count of  $> 1000$  cells/mcL?  **YES**  **NO**
- Is the patient stable on HES therapy for at least 4 weeks?  **YES**  **NO**

**For add on therapy for CRSwNP:**

- Was diagnosis confirmed with anterior rhinoscopy, or endoscopy, or sinus CT?  **YES**  **NO**
- Did the patient have inadequate response to sinonasal surgery, or is the patient not a candidate for sinonasal surgery?  **YES**  **NO**
- Has the patient tried and had an inadequate response to oral systemic corticosteroids, or has an intolerance, hypersensitivity, or contraindication to therapy with oral systemic corticosteroids?  **YES**  **NO**
- Has the patient tried and had an inadequate response to intranasal corticosteroids used for at least a 3-month trial or has an intolerance or hypersensitivity or contraindication to therapy with intranasal corticosteroids?  **YES**  **NO**
- Is the patient currently treated with standard nasal polyp maintenance therapy (ie. nasal saline, irrigation, intranasal corticosteroids) and will continue in combination with the requested agent after starting Nucala?  **YES**  **NO**

**For all patients:**

- Does the patient have a history of anaphylaxis?  **YES**  **NO**
- Is this patient ambulatory?  **YES**  **NO**

GENERAL INFORMATION / NOTES:

- Please include a copy of RX to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.
  - **\*\* NOTE \*\*** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
  - *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
  - *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** *Please notify our office if the medication is discontinued.*

Ordering Provider Signature: \_\_\_\_\_