



PATIENT INFORMATION (Complete or Fax Existing Chart) PRESCRIBER INFORMATION

Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____
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INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____
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CLINICAL INFORMATION

J45.50 Severe persistent asthma, uncomplicated
 J45.51 Severe persistent asthma with (acute) exacerbation
 J82.83 Eosinophilic asthma
 J33.0 Polyp of the nasal cavity
 M30.1 Polyarteritis with lung involvement [Churg-Strauss]
 Other: _____

Prior Anaphylactic Reaction: No Yes (Reason/Date): _____

Other Medications: _____

Lab Results:

Positive Skin or RAST test to Perennial Aeroallergen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Test Date: _____ - _____ - _____
Serum IgE Level _____ IU/ML	Test Date: _____ - _____ - _____
Serum Eosinophil Level: _____ cells/mcL	Test Date: _____ - _____ - _____
Sputum Eosinophiles _____ cells/mcL	Test Date: _____ - _____ - _____

NUCALA® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection: _____

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Nucala (mepolizumab) 100mg/mL	<input type="checkbox"/> Inject 100mg under the skin once every 4 weeks. <input type="checkbox"/> Inject 300mg (3 separate 100mg injections) under the skin once every 4 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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