vitalcare INFUSION SERVICES of FLORENCE

Pharmacy Name: **Vital Care of Florence**
Address: **161 Dozier Blvd, Suite 100**
City/State/Zip: **Florence, SC 29501**
Phone: **843-954-0010**
Fax: **843-954-0011**
Email: **info@vcflorence.com**

Nucala Referral Form

Attach Demographic Information & Insurance Cards (front/back copies) if needed

Patient Name:	DOB: Gender:
Address:	Primary Phone:
City: State: Zip:	Alt Phone:
Email:	SSN# (last 4 # required):
Weight (required): Height (required): ft in	Home Medication List Attached: ☐
☐ NKA Allergies:	☐ Allergy list attached

Diagnosis & Clinical Documentation ICD-10 Code: *

** Please attach CLINICAL PROGRESS NOTES, TESTS, LABS, HISTORY OF ATTEMPTED/FAILED TREATMENTS to support diagnosis & treatment**

- ☐ Severe Asthma with Eosinophilic Phenotype
- ☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
- ☐ Chronic Obstructive Pulmonary Disease (COPD) with Eosinophilic Phenotype
- ☐ Eosinophilic Granulomatosis with Polyangiitis (EGPA)
- ☐ Hypereosinophilic Syndrome (HES): ≥6 months without non-hematologic secondary cause

☐ Other Diagnosis: _____

☐ Supporting Documentation: Absolute Eosinophil Level (> 300 in prior 12 mos or > 150 in prior 6 weeks) & Pulmonary Function Test (PFT) to include FEV1 score (for Asthma). Anti-neutrophil cytoplasmic antibody (+) in last 6 months (for EGPA). Documented herpes zoster vaccine (if available for all indications). Nasal corticosteroid use in ≥ last 8 weeks (for CRwNP).

Provider attestation for Nucala to be HCP-administered based on below:

- ☐ Patient/Caregiver are not competent or not physically able to self-administer.
- ☐ History of uncontrolled disease and self-administration is not advisable.
- ☐ Circumstances and location for self-administration are not adequate with risk for treatment of anaphylaxis.
- ☐ History of hypersensitivity reactions within the past 6 month, such as: anaphylaxis, angioedema, bronchospasms, or hypotension.
- ☐ Specific rational:

Prescription Information ☑ Refills x 12 months unless otherwise noted here:

Medication	Dosing and frequency of subcutaneous injection given in thigh, abdomen, or upper arm.	Standard Protocol
Nucala (mepolizumab)	☐ 100 mg subcutaneous every 4 weeks. **Indicated in Severe Asthma in PEDIATRIC ages 6-11 weighing less than 40 kg:** ☐ 40mg subcutaneous every 4 weeks **Indicated in EGPA or HES diagnosis:** ☐ 300 mg as (3) separate 100 mg subcutaneous injections every 4 weeks.	**Extended POST injection monitoring for first (3) doses per facility protocol.**

Specify past/current treatments attempted/failed:

Last known dose: ☐ No washout period required ☐ Provider request washout period of:

Additional Orders/Instructions	Ancillary Orders as per Protocol	Anaphylaxis & Adverse Reaction Orders
	* Supplies as required * Start Peripheral IV/Access VAD if needed. * NaCl 0.9% flushing/locking as required * Heparin flushing/locking as required	*Administer anaphylaxis medications as per the Standing Adverse Reaction Protocol provided by Vital Care of Florence, access on our website or via QR code.

Physician Information

Prescriber Name:	DEA#:	License #:
Name of Practice:	Office Contact:	
Address:	City, State, Zip:	
Phone #:	Fax #:	Email:

I authorize Vital Care Infusion Services, LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____ Date:_____ NPI#:_____

Prescriber must MANUALLY SIGN- Stamped signatures, signature by other personnel, & computer generated signatures will not be accepted.

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