Nucala Injection Order

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:
❒ Demographics ❒ Insurance Information
❒ H & P Relevant to the Diagnosis ❒ CBC (Eosinophil Count)
❒ Medications List Including High Dose ICS

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ◯ lbs / ◯ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

NUCALA (MEPOLIZUMAB)

Date of Last Treatment, If Continuation:

100 mg subcutaneous Q 4 weeks

Exacerbation History 2 or more in prior 12 months: _____

Blood eosinophil level must be ≥ 150 cells/mL: _____