Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

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

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

Preferred Treatment Location	◻ Voorhees ◻ Wall/Manasquan ◻ Hamilton	◻ Moorestown ◻ Sewell ◻ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:	

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

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 ≥ 150 cells/uL at baseline (within 6 weeks of initial dosing) **or** an elevated peripheral blood eosinophil level of ≥ 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/mm3? ◻ **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) ≥ 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.*

◻ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature: _____