Please fax both pages of completed form to your team at 866.531.1025.

To reach your team, call toll-free 866.839.2162.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form Nucala[®] (mepolizumab)

Four simple steps to submit your referral.

1 **Patient Information**

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Please provide copies of front and back of all medical and prescription insurance cards.

accredo

New patient	Current patient			
Patient's first name	е		Last name	Middle initial
Sex at birth: Ma	ale Female Preferred	pronouns	Last 4 digits of SSN	Date of birth
Street address				Apt #
City			_ State	Zip
Home phone		Cell phone	E-mail address	
Parent/guardian (if	applicable)			
			E-mail address	
Alternate caregiver	/contact			
Home phone		Cell phone	E-mail address	
OK to leave mes	ssage with alternate care	giver/contact		
Patient's primary la	anguage: English	Other If other, please sp	ecify	

2 **Prescriber Information**

All fields must be completed to expedite prescription fulfillment.

Date	Time	Date medication needed		
Office/clinic/institution name				
Prescriber info: Prescriber's first name Last name				
Prescriber's title	If NP or PA, under direction of Dr			
Office phone	Fax	NPI #	License #	
Office contact and title	Office contact e-mail			
Office street address				Suite #
City	State			Zip
Infusion location: Patient's home		If infusion site, complete information		
Infusion info: Infusion site name		Clinic/hospital affiliation		
Site street address			S	uite #
City	State			Zip
Infusion site contact	Phone	Fax	_ E-mail	

Clinical Information

D-10 code (REQUIRED):
NKDA Known drug allergies
or anaphylactic reaction: No Yes (Reason/date)
ncurrent meds
ncomitant therapies: Short-acting beta agonist Long-acting beta agonist Antihistamines Decongestants Immunotherapy
Inhaled corticosteroid Leukotriene modifiers Oral steroids Nasal steroids Other
b results: History of positive skin OR RAST test to a perennial aeroallergen
e-treatment serum IgE level IU per mL Test date Pre-treatment serum eosinophils cells/mcL
d/or sputum eosinophils bate wt obtained Patient wtkg Date wt obtained
O Specialty (required): Allergist Pulmonologist ENT Primary care Pediatrician Other
escription type: Naïve/new start Restart Continued therapy

Patient's first name	Last name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

4 Prescribing Information

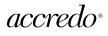
Medication/Strength/Formulation	Directions	Quantity/Refills
Nucala® (mepolizumab) 100mg vial Nucala® (mepolizumab) 100mg/mL autoinjector pen Nucala® (mepolizumab) 100mg/mL single-dose prefilled syringe	Inject 100mg under the skin once every 4 weeks Inject 300mg (3 separate 100mg injections) under the skin once every 4 weeks	1-month supply 3-month supply Other: Refills
Single-dose prefilied syringe Nucala vial supplies: • Sterile water for injection 10mL vial for reconstitution QS per doses • Alcohol swabs • Flexible bandages 1" x 3" • 3mL syringe with 21G x 1" Safety Glide needle for reconstitution • 1mL syringe with 27G x 1/2" Safety Glide needle for subcutaneous injection No supplies (Supplies will be sent with shipment unless indicated.)		Send quantity sufficient for medication days supply

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN				
HERE	Date	Dispense as written	Date	Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.



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