

Four simple steps to submit your referral.

1 PATIENT INFORMATION New patient Current

Patient's name _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Home phone _____ Work phone _____
 Cell phone _____ Evening phone _____
 E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____
 Phone _____
 Insured's name _____
 Insured's employer _____
 Relationship to patient _____
 Identification # _____
 Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____
 Group # _____
 Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's name and title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____
 Deliver product to: Office Clinic
 Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
 NKDA Known drug allergies _____
 Prior anaphylactic reaction: Yes (Reason/date _____) No
 Concurrent meds _____
 Concomitant therapies: Short-acting beta agonist Long-acting beta agonist
 Antihistamines Decongestants Immunotherapy Inhaled corticosteroid
 Leukotriene modifiers Oral steroids Nasal steroids Other _____
 Lab results: History of positive skin OR RAST test to a perennial aeroallergen
 Pre-treatment serum IgE level _____ IU per mL Test date _____
 Pre-treatment serum eosinophils _____ cells/mL
 and/or sputum eosinophils _____ Date _____
 Patient wt _____ kg Date wt obtained _____
 MD Specialty (required): Allergist Pulmonologist ENT Primary care Pediatrician
 Other _____
 Prescription type: Naïve/new start Restart Continued therapy

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation and Directions	Quantity/Refills
Nucala® (mepolizumab) 100 mg vial <input type="checkbox"/> Asthma <input type="checkbox"/> EGPA	<input type="checkbox"/> Inject 100 mg subcutaneously once every 4 weeks <input type="checkbox"/> Inject 300 mg (3 separate 100 mg injections) subcutaneously once every 4 weeks Note: to be administered by a healthcare provider	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
Nucala supplies: • Sterile water for injection 10 mL vial for reconstitution QS per doses • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL syringe with 21G x 1" Safety Glide needle for reconstitution • 1 mL syringe with 27G x 1/2" Safety Glide needle for subcutaneous injection <input type="checkbox"/> No supplies (Supplies will be sent with shipment unless indicated.)		Send quantity sufficient for medication days supply

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

By signing below, I certify that the above therapy is medically necessary.

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

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

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

Please fax completed form to your team at 866.531.1025.

To reach your team, call toll-free 866.839.2162.