



# Nucala (Mepolizumab)

INFUSION THERAPY CENTERS

New Referral     Restart     Medication Order Change

## PATIENT INFORMATION

Name \_\_\_\_\_  
Date \_\_\_\_\_  
DOB \_\_\_\_\_  
SS# \_\_\_\_\_  
Phone # \_\_\_\_\_  
Email \_\_\_\_\_

## PHYSICIAN INFORMATION

Referring Physician \_\_\_\_\_  
Practice Address \_\_\_\_\_  
Office Contact Name \_\_\_\_\_  
Contact Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
NPI / TIN \_\_\_\_\_

## MEDICATION ORDERS

Dosing:  100mg      Frequency:  Once every 4 weeks

Indication / Diagnosis:

- J.45.50 Severe persistent asthma, uncomplicated
- J.45.51 Severe persistent asthma with acute exacerbation
- J.45.50 Severe persistent asthma with status asthmaticus
- Other (*please specify in additional information*)

Additional Information:

ICD-10 (Required) \_\_\_\_\_

MD Signature \_\_\_\_\_ Date \_\_\_\_\_

## REQUIRED DOCUMENTATION

Please send the following documents and records. This will help streamline the pre-authorization process.

- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- If this is a continuation of a treatment, include the last infusion note
- Current medication list

Most recent diagnostics results to include:

- Eosinophil phenotype (EOS) (drawn within the last 3 months)
- If available, radioallergosorbent test (RAST) results

*We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.*

**AZIVinfusion.com | CALL CENTER: 602.386.4968 | FAX: 623.594.8533**

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