



Phone: 616-954-0600 Fax: 616-954-1675

Nucala Injection

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and Recent Visit Notes

Referral status: NEW referral Dose or frequency change Order renewal

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Patient Weight: _____ lbs / kg Height: _____

ICD-10 : _____, _____, _____

For asthma patients ONLY:

Does the patient currently use tobacco products? Yes No

What is the patient's peripheral blood eosinophil count? _____ cells/mcL; Date drawn: _____

Has the patient had 3 or more asthma exacerbations in the past year? No Yes please select all that apply:

- Oral steroids were required for at least 3 days
- Exacerbation resulted in an ED visit and/or hospitalization

Has patient been compliant on high dose ICS/LABA inhaler for at least 3 months? Yes No

In the past 6 months, what medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use

Nucala (mepolizumab) Subcutaneous Injection:

Severe Asthma (age 6-11 years): 40 mg

Severe Asthma (age 12 and older): 100 mg

EGPA: 300 mg

HES: 300 mg

Frequency: Every 4 weeks Other: _____

Rx Expiration Date: ____/____/____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____ **Office Fax Number:** _____