NUCALA (MEPOLIZUMAB) Referral Order Form

PACE HEALTHCARE LLC

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions *indicate name of drug(s) _____

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

NUCALA MEDICATION ORDERS

Dose: ☐ 100mg ☐ 40mg (ages 6 to 11)

Frequency: ☐ Once every 4 weeks

INDICATION/DIAGNOSIS

☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.51 Severe persistent asthma with acute exacerbation
☐ J45.52 Severe persistent asthma with status asthmaticus
☐ Other _____

***ICD-10 _____ required**

NOTES (ADDITIONAL INFO)

_____
Referring Physician's Signature

_____
Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Eosinophils

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY