Nucala® Referral Form

4510 Richmond Road
Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: ______________________ **NPI:** ______________________

Phone: ______________ **Fax:** ______________ **Office Contact:** ______________

Address: ____

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Patient Information

Name: ______________________ **DOB:** ______________ ☐**M** ☐**F**

Address: ____

Phone: ______________ **2nd Phone:** ______________ **MRN:** ______________

Primary Language: ______________ **Functional Limitations:** ______________

Clinical Information

Diagnosis (Include ICD-10 code): ____

Weight:__________ ☐lb ☐kg **Height:**__________ ☐in

Allergies: ______________________________ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: ______________________________

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Has the patient previously received Cinqair® or Xolair®? ☐Yes ☐No If yes, were any signs of allergic reaction observed? ☐Yes ☐No

Is this the patient's first dose? ☐Yes ☐No (If no, date of last dose: __________) **Response to prior doses**: ______________

Has the patient ever had an anaphylactic-type reaction to a medication or food? ☐Yes ☐No

Has the patient previously received the shingles vaccines? ☐Yes ☐No **Does the patient have a history of parasitic infection?** ☐Yes ☐No

Is patient up-to-date with immunizations? ☐Yes ☐No ☐Home Care to provide immunizations in conjunction with current guidelines

Additional Notes: ____

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Prescription Information

☐ **Nucala® 100mg vial:** Administer 100 mg SQ every four weeks. Home Care to provide supply items and nursing care to prepare and administer product as per package instructions.
Site of Care: Home Care Infusion Center

Quantity: ______________ **Refills:** ______________

Lab orders: Below please list any outpatient laboratory work related to this therapy you would like Home Care to draw while the patient is on site. Be sure to include the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated.

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Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ______________________________ **Date:** ______________

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