# ADVANCED PHARMACY SOLUTIONS

## NUCALA REFERRAL FORM

26611 Cabot Road Suite B | Laguna Hills CA 92653
Ph 949-348-7900|Toll Free 800-464-7736 |Fax 949-348-7920
NPI# 1922103142 NABP# 0547185
info@aps-rx.net APS-rx.net

Today's Date _____

Date Needed _____

☐ Phone Order
**Ship to Patient:**
☐ Home ☐ Work
**Ship to:**
☐ Physician Office
☐ Nurse / Training
☐ APS Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female

Address_____ Apt #_____ City_____ State_____ Zip_____

Telephone_____ Cell_____ SSN_____ Email_____

Allergies_____ Comorbidities_____

Current Medications (including OTC, if necessary, please fax a complete list)_____

Primary Insurance_____ ID#_____ Group #_____

Secondary Insurance _____ ID# _____ Group # _____

Insured's Name _____ Employer _____

City _____ State _____ Phone _____ **Please attach patient's insurance cards, front and back**

Diagnosis ICD-10 Code: ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Other _____

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: _____Cells/µL Date of test:_____/_____/_____

Number of asthma exacerbations (requiring use of systemic corticosteroids and/or hospitalization) in last 12 months: _____

## PRESCRIPTION

**PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS (Front and Back)**

| Medication | Directions | Quantity | Refills |
|---|---|---|---|
| Nucala™ (mepolizumab) | ☐ 100mg in single-dose prefilled syringe administered by subcutaneous injection once every 4 weeks<br>☐ _____ | ☐ 1<br>☐ _____ | ☐ 1<br>☐ 2<br>☐ 3<br>☐ # Refills |

**Has the patient been started on a samples?** ☐ **Yes** ☐ **No**

Total number of Nucala (mepolizumab) doses received since start date: _____ Date of last injection/treatment:_____

**Please attach the following:** **Most Recent Progress Notes**
**Lab Results** (**High eosinophil count**)
**Full Medication List** (**need evidence of inhaled corticosteriod use**)

**Thank you!**

Prescriber's Name / Practice _____ Office Contact_____

Address_____ Suite#_____ City_____ State_____ Zip_____

Tel_____ Fax_____Email _____

License#_____ NPI#_____ UPIN#_____ DEA# _____

**Prescriber's Signature** (signature required. NO STAMPS)_____ **Date**_____



Please fax completed referral form to
**APS** at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.