



NEWPORT SUPERIOR
MEDICAL & INFUSION

NEWPORT INFUSION NUCALA REFERRAL FORM

1501 Superior Ave Suite 202 | Newport Beach CA
92663 Ph 949-601-6001 | Fax 866-542-8631

NPI# 1184620866

newportinfusion.com

Today's Date _____

Date Needed _____

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

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: _____ Cells/ μ L 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 TM (mepolizumab)	☐ 100mg in single-dose prefilled syringe administered by subcutaneous injection once every 4 weeks	☐ 1 ☐ _____	☐ 1 ☐ 2 ☐ 3 ☐ _____ # 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 corticosteroid 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 _____

LEGAL NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. This prescription may be filled at a pharmacy of the patient's choice.

Please fax completed referral form to
Newport Infusion at (949)484-4150