



Nucala 
(mepolizumab)

Select location:

Akron	Cleveland (North Olmsted)	Liberty	Springfield
Anderson	Columbus (East Broad)	Lima	Toledo
Athens	Columbus (Hilliard)	Mansfield	Troy
Canton	Columbus (Worthington)	Mentor	Warren
Cincinnati (Blue Ash)	Dayton (Beavercreek)	Perrysburg	Youngstown
Cincinnati (West Side)	Dayton (Englewood)	Sandusky	Zanesville
Cleveland (Mayfield)	Findlay	Solon	Crestview Hills (KY)

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M F	Weight:	Lbs Kg
Patient Status: New to therapy Continuing therapy Next due date (if applicable):			

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

Severe Asthma (ages 6+) with Eosinophilic Phenotype (_____) EGPA (_____)
 Chronic Rhinosinusitis with Nasal Polyps (_____) Other (_____)
 COPD with Eosinophilic Phenotype (_____) HES (ages 12+) without an ID Non-Hematologic 2 Cause (_____)

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

NUCALA Administer 100mg SubQ every 4 weeks OR Administer _____ Vital signs per HI Protocol Anaphylaxis & Hydration Management per HI Protocol	PRE-MEDICATIONS N/A
	Acetaminophen 500mg 650mg 1000mg
	Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
	Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
	Prednisone _____ mg PO
	Other _____
	POST-MEDICATIONS N/A
	Acetaminophen 500mg 650mg 1000mg
	Prednisone _____ mg PO
Other _____	

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____

DATE _____