(mepolizumab)

NUCALA infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Severe Allergic Asthma with Eosinophilic Phenotype > 12

☐ _____ yro Adult Eosinophilic Granulomatosis with Polyangiitis

☐ _____ (EGPA)

(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

☐ Length of Need _____

NUCALA ORDERS

DOSAGE

◯ 100mg SQ, every 4 weeks

◯ 300mg SQ as separate 100mg injections, every 4 weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

Notes

◯ Refills: _____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887