

NUCALA (MEPOLIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

- Severe asthma (age 6+): J45.50 J45.52 J45.51 Hypereosinophilic syndrome: D72.119
 Chronic rhinosinusitis w/ nasal polyps: J.33.8 Other: _____
 Eosinophilic granulomatosis w/ polyangiitis: M30.1

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

- Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Nucala	<input type="checkbox"/> 100mg <input type="checkbox"/> 40mg <input type="checkbox"/> 300mg <input type="checkbox"/> 300mg	<input type="checkbox"/> Subcutaneous Inj	<input type="checkbox"/> Every 4 weeks

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS