Local Infusion

MYLOCALINFUSION.COM

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

❑ Chronic rhinosinusitis w/ nasal polyps: J.33.8

❑ Eosinophilic granulomatosis w/ polyangiitis: M30.1

❑ Hypereosiniophilic syndrome: D72.119

❑ Other: _____

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

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Nucala	❑ 100mg ❑ 40mg ❑ 300mg ❑ 300mg	❑ Subcutaneous Inj	❑ Every 4 weeks

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

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ NH: 603.217.5371 ❑ ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: _____