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: ❑ CT: 203.433.0621 ❑ ME: 207.407.7272 ❑ NH: 603.217.5371 ❑ NJ: 201.581.4521

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