

- Borough Park**  
1428 36th Street  
Suite 107  
Brooklyn, NY 11218
- Crown Heights**  
555 Lefferts Avenue  
Brooklyn, NY 11225
- Manhattan**  
57W 57Street  
Suite 601  
New York, NY 10019
- Manhasset**  
333 East Shore Road  
Suite 201  
Manhasset, NY 11030
- Rockville Centre**  
165 North Village Avenue  
Suite 133  
Rockville Center, NY 11570
- Elmsford/Tarrytown**  
555 Taxter Road  
3rd Floor  
Elmsford, NY 10523
- NYC Central Park West**  
115 Central Park West  
Suite 15  
New York, NY 10023
- Woodbury**  
75 Froehlich Farm  
Woodbury, NY 11797
- Staten Island**  
27 New Dorp Lane  
Staten Island, NY 10306



- Manhattan**  
225 E 70th Street  
Suite 1E  
New York, NY 10021
- Queens**  
64-05 Yellowstone Blvd  
CF104  
Forest Hills, NY 11375
- Manhattan**  
225 East 70th Street  
New York, NY 10021
- Holbrook/Ronkonkoma**  
233 Union Ave  
Suite 207  
Holbrook, NY 11741
- Scarsdale**  
495 Central Park Avenue  
Suite 205  
Scarsdale, NY 10583
- 5 Towns**  
141 Washington Avenue  
Cedarhurst, NY 11559
- Long Beach**  
917 Beech Street  
Long Beach, NY 11561
- Riverhead**  
1228 E Main Street  
Suite A  
Riverhead, NY 11901
- Bronx**  
226 West 238th Street  
Bronx, NY 10463

(mepolizumab)

# NUCALA

Infusion orders

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA	Allergies:	Weight lbs/kg:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**DIAGNOSIS** *Please provide ICD-10 code*

\_\_\_\_\_ Severe Allergic Asthma with Eosinophilic Phenotype > 12 yro

\_\_\_\_\_ Adult Eosinophilic Granulomatosis with Polyangiitis ( EGPA)

\_\_\_\_\_

**PRE-MEDICATION**

Tylenol 1000mg PO                       Solu-Medrol 125mg IVP  
 Diphenhydramine 25mg PO             Solu-Cortef 100mg IVP  
 Cetirizine 10mg PO                       Diphenhydramine 25mg IVP  
 \_\_\_\_\_ (other)                             \_\_\_\_\_ (other)

**SPECIAL INSTRUCTIONS**

**NUCALA ORDERS**

100mg SQ, every 4 weeks  
 300mg SQ as separate 100mg injections, every 4 weeks  
 Other \_\_\_\_\_

**PATIENT WEIGHT**

\_\_\_\_\_ lbs.

\_\_\_\_\_ kg

**TOTAL DOSES:**

1 yr \_\_\_\_\_   
  Other \_\_\_\_\_   
  Refill \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

## ORDERING PROVIDER

Signature   X   \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_