Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

Office: 212-803-3339 Fax : 646-768-8600

(mepolizumab)

NUCALA

Infusion orders

Date: ____________________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ ______________________ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ______________________ *(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 ______________