

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



(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 \_\_\_\_\_