Nucala Order Form
(mepolizumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

☐ D72.119 Hypereosinophilic Syndrome (HES), Unspecified
☐ J45.50 Severe Persistent Asthma, Uncomplicated
☐ J45.51 Severe Persistent Asthma, w/ Acute Exacerbation
☐ J45.52 Severe Persistent Asthma, w/ Status Asthmaticus
☐ M30.1 Polyarteritis w/ Lung Involvement (Churg-Strauss)
Other: _____

Prescribing Information

Do not discontinue systemic or inhaled corticosteroids (ICS) abruptly upon initiation of therapy. Nucala should NOT be used to treat acute asthma symptoms or acute exacerbations.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Blood Eosinophil Level (Pre-treatment baseline count ≥ to 400 cells/mcL) (Absolute Eosinophil in K/mcL x1000 = cells/mcL)**

PRESCRIPTION

Nucala (mepolizumab)

Dose: (SELECT ONE)
☐ **SubQ:** Inject 100 mg every 4 weeks for one year
☐ **SubQ:** Inject 300 mg every 4 weeks for one year

Pediatric Dose (aged 6-11 years old):
☐ **SubQ:** Inject 40 mg every 4 weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first injection.

Comments: _____

_____

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_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____