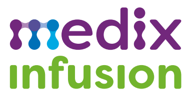

Nucala Order Form
(mepolizumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ____________________

DOB: ____________ Phone: ____________ Sex: M F

DIAGNOSIS & CLINICAL INFORMATION

Primary ICD 10 Code (Required)

- D72.119 Hypereosinophilic Syndrome (HES)
- J45.50 Severe Persistent Asthma, Uncomplicated
- J45.51 Severe Persistent Asthma, w/Acute Exacerbation
- M30.1 Eosinophilic Granulomatosis with Polyangitis (EGPA)
- J82.83 Eosinophilic Asthma
- Other: ____________

Patient Status:
- New to therapy
- Continuing therapy
(date of last dose ____________)

Weight: ________ **lb** **kg** **Height:** ________

Allergies: ____________

PRESCRIPTION

NUCALA (mepolizumab)

Adult Dose:

SubQ: Inject 100 mg every 4 weeks for one year
SubQ: Inject 300 mg every 4 weeks for one year (EPGA & HES dosing)

Pediatric Dose:

SubQ: Inject 40 mg every 4 weeks for one year

Is the patient on any other disease modifying therapy? **Yes** **No**

Is yes, please note therapy and last dose: ____________

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

Other Orders: ____________

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Lab Results: Blood eosinophil level OR CBC with differential AND pulmonary function test prior to initiating therapy

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: ____________

Signature: ____________

NPI #: ____________ Date: ____________

Supervising Physician (if applicable): ____________

Address: ____________

City: ____________ State: ____________ Zip: ____________

Contact Name: ____________ Phone: ____________ Fax: ____________