Infusion Solutions Inc.
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NUCALA (mepolizumab) ORDER FORM

PATIENT NAME:_____ DOB:_____ WT:_____ HT:_____

ALLERGIES:_____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: NUCALA **(mepolizumab)** ❒NO ❒YES LAST DOSE DATE: _____

DIAGNOSIS:_____ ICD 10 CODE(S):_____

MEDICATION ORDERS

DOSE/FREQUENCY:

Maintenance orders are valid for 1 year. For a shorter duration, indicate here: _____

❒Severe eosinophilic asthma **in children aged 6 to 11 years**: 40 mg SQ every 4 weeks
❒Severe eosinophilic asthma **in patients 12 years and older**: 100 mg SQ every 4 weeks
❒Chronic obstructive pulmonary disease (COPD): 100 mg SQ every 4 weeks
❒Chronic rhinosinusitis with nasal polyps: 100 mg SQ every 4 weeks
❒Eosinophilic granulomatosis with polyangiitis (Churg-Strauss): 300 mg SQ every 4 weeks
❒Hypereosinophilic syndrome in patients 12 years and older: 300 mg SQ every 4 weeks
❒Other: _____

STANDARD ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- Obtain weight before each dose.
- Monitor vital signs (temp, HR, RR, BP) before and after therapy administration.
- If an infusion reaction occurs, monitor vital signs until symptoms subside. If the reaction persists or worsens, initiate reaction protocol and notify provider.
- Observe patient for 15-30 minutes after completion of therapy.

LABS

LAB ORDERS:

❒ _____

LAB FREQUENCY:

❒ _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- Asthma and COPD: Spirometry/pulmonary function tests
- Hypereosinophilic syndrome and eosinophilic granulomatosis with polyangiitis: Baseline eosinophil count (CBC w/diff)

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Evaluation for presence of parasitic infections
- Review that all age-appropriate vaccinations are up-to-date as per current immunization guidelines
- Consider Herpes Zoster vaccination if medically appropriate

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution)

PRESCRIBER SIGNATURE (dispense as written)

PRINT NAME (FIRST AND LAST)

DATE