

# NUCALA® (mepolizumab)

## Patient Information

Full Name: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  
DOB: \_\_\_\_\_ Allergies:  NKDA \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Patient Status:  New to therapy  Continuing therapy Last Treatment Date: \_\_\_\_\_ Next Treatment Date: \_\_\_\_\_


## Required Documentation

- Patient Demographics and Insurance Card  Medication List  Recent labs including eosinophil count  
 Clinical/Progress Notes Supporting Dx  Pulmonary Function Test (is asthma dx)

## Primary Diagnosis

-  ICD-10 Code (required): \_\_\_\_\_  
 Severe asthma  Hyper-eosinophilic syndrome (HES)  
 Eosinophil Granulomatosis with Polyangiitis (EGPA)  Chronic rhinosinusitis with nasal polyps (CRSwNP)  
 Other: \_\_\_\_\_

## Therapy Administration

- Nucala 100mg subQ every 4 weeks  Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)  
 Nucala 300mg subQ every 4 weeks  RN to administer ordered therapy per manufacturer guidelines.  
 Other: \_\_\_\_\_  Other: Please fax alternative reaction orders or nursing administration orders if checking this box
- Refills:**  
 x 1 year  Other: \_\_\_\_\_
-  Order valid for one year unless otherwise stated

## Special Orders

## Provider Information

Provider Name: \_\_\_\_\_ Office Contact Person: \_\_\_\_\_  
Referring Practice Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Referring Practice Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Provider NPI: \_\_\_\_\_  
Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_