RED RIVER HEALTH
Ambulatory Infusion Clinic

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NUCALA (mepolizumab) Injection Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Severe Eosinophilic Asthma ☐ _____ _____
other

Previous Drug Therapies/Tried & Failed:

☐ Cinqair ☐ Fasenra ☐ Xolair ☐ Other: _____ Date of Last Dose: _____

Pre-Medication:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet
☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☑ Blood Eosinophil result & date *(please attach)*

NUCALA ORDERS:

Dosing: ☐ 100 mg SQ ☐ 300 mg SQ

Frequency: ☐ every 4 weeks ☐ Other: _____

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____