Palmetto INFUSION

Phone: 1-800-809-1265 Fax: 1-866-872-8920

MRN:_____

DOB:_____

STANDARD Nucala® (mepolizumab) PLAN OF TREATMENT

NOTE: Patient ***may be ineligible*** to receive **Nucala® (mepolizumab)** if patient has signs/symptoms of parasitic infection, is currently being treated for a parasitic infection, or is having acute bronchospasm and/or asthma attack.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. Diagnosis:

☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation

☐ J45.52 Severe persistent asthma with status asthmaticus

☐ Other **ICD-10 Code/description:** _____

Dose/Frequency:

Nucala® (mepolizumab) 100 mg every four (4) weeks via subcutaneous injection

(*Administer as subcutaneous injection only to upper arm, thigh, or abdomen)*

☐ Patient to continue Nucala unless:

- Previous allergic reaction
- Parasitic infection
- Pregnancy
- Other: _____

Extended post treatment monitoring for any patient new to therapy: monitor patient for one (1) hour after first injection, for 30- minutes after second injection, and then 15-minutes after each injection thereafter.

Special Orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

4. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

5. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

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DOB:_____

Guidelines for Prescribing Nucala® (mepolizumab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-5)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any documented use of inhaled or oral corticosteroids, glucocorticoids, theophylline, leukotriene modifiers, short or long acting beta-agonists. Any lab results and/or Pulmonary Function Tests to support diagnosis.**

- NUCALA® is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa) indicated for: Add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

☐ If patient is switching biologic therapies such as Xolair® or Cinqair®, then MD must specify wash-out period prior to starting NUCALA® as specified of_____weeks.
Last known therapy:_____and last known date received:_____.

☐ Other as requested: _____
_____

Pre-Screening:

☐ Blood Eosinophil Level (Pre-treatment baseline count greater than or equal to 150 cells/mcL)
(Absolute Eosinophil in K/µL x 1000 = cells/mcL)

** **Warnings/Precautions:** **Hypersensitivity reactions:** (e.g., anaphylaxis, angioedema, bronchospasm, hypotension, urticaria, rash) have occurred after administration of NUCALA®. Discontinue NUCALA® in the event of a hypersensitivity reaction. Do not use to treat acute bronchospasm or status asthmaticus. The most common adverse reactions (incidence ≥5%) include headache, injection site reaction, back pain, and fatigue. **Herpes zoster infections**: have occurred in patients receiving NUCALA®. Consider vaccination if medically appropriate. **Helminth Infections:** Treat patients with pre-existing parasitic infections before therapy. If patients become infected while receiving treatment with NUCALA® and do not respond to anti-helminth treatment, then discontinue NUCALA® until parasitic infection resolves. **Corticosteroids:** Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy. Decrease corticosteroids gradually, if appropriate. **Pregnancy/Breastfeeding:** Discuss Pregnancy or breastfeeding plans/risks prior to start of therapy. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 6/19/19