MRN:_____

DOB: _____

STANDARD Nucala® (mepolizumab) PLAN OF TREATMENT for EGPA

(Re) Certification Period From_____**to** _____

NOTE: Patient ***may be ineligible*** to receive **Nucala® (mepolizumab)** if receiving antibiotics for active infectious process, antifungal infection, active herpes zoster infection, active fever and/or suspected infection, having acute bronchospasm and/or asthma attack, or without clearance after surgery.

1. Patient Name:_____Height (inches):_____Weight (lbs):_____

2. Allergies: _____

3. Diagnosis:

☐ M30.1 Polyarteritis with lung involvement (Eosinophilic Granulomatosis with Polyangiitis: Churg-Strauss Syndrome)

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

Orders: Obtain weight each visit. Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Assess patient for response to therapy. Supplies needed to complete prescribed therapy. **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 all patients for 15-minutes after each injection thereafter. Pharmacist to perform clinical drug monitoring. *If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.*** Utilize existing central line or initiate a peripheral IV as needed for treatment of Adverse Reactions. Sodium Chloride 0.9% flush 3-10 ml and/or Heparin flush 100 units/ml 1-5 ml per line type if needed for treatment of Adverse Reactions.

Dose/Frequency:

Nucala® (mepolizumab) 300 mg every four (4) weeks via subcutaneous injection

(*Administer as (3) separate 100 mg subcutaneous injections only to upper arm, thigh, or abdomen injected at least 2 inches apart.)*

Special orders: _____

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

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

Printed Physician's Name with Credentials:_____NPI: _____

MRN:_____

DOB: _____

Guidelines for Prescribing Nucala® (mepolizumab) for EGPA

(Required documentation with all initial referrals)

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

☐ Include signed and completed **Plan of Treatment**.

☐ 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 corticosteroids, azathioprine, methotrexate, mycophenolic acid and/or cytotoxic agents such as cyclophosphamide. Any lab results and/or Pulmonary Function Tests to support diagnosis.**

- NUCALA® is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa) indicated for the treatment of adult

☐ If patient is switching from a cytotoxic agent such as cyclophosphamide, 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

** **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 manifestations of systemic allergic/hypersensitivity reactions reported in the group receiving 300 mg of NUCALA® included rash, pruritus, flushing, fatigue, hypertension, warm sensation in trunk and neck, cold extremities, dyspnea, stridor, and angioedema. Injection site reactions:** Including pain, erythema, swelling. **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.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.