Palmetto INFUSION®

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

| Referral Status: | | MRN: |
|---|---|---|
| ☐ New referral | ☐ Order change | ☐ Order Renewal |
| Patient preferred clinic: | | |

# Nucala® (mepolizumab) Standard Plan of Treatment for Nasal Polyps

## PATIENT DEMOGRAPHICS:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Referral: | | | | Patient's Phone: | | | |
| Patient Name: | | | | Address: | | | |
| Date of Birth: | | | | City, State, Zip: | | | |
| Height in inches: | Weight: | LB or | KG | Gender: | Allergies: | ☐ See list | ☐ NDKA |

## DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING )

| | |
|---|---|
| ☐ | J33.8 - Chronic rhinosinusitis with nasal polyp |
| ☐ | _____ - Other: |

## REQUESTED DOCUMENTATION:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Full medication list |
| 4 | Tried and failed therapies |

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

| | |
|---|---|
| IF NO: | IF YES: |
| PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INJECTION DATE: |
| | NEXT INJECTION DATE: |
| | **IF ORDER CHANGE:** |
| | ☐ **Continue current order until insurance approved** |

**Provider Attestation for HCP administration:**

☐ Provider attestation that the patient or caregiver are not competent or are physically unable to administer the Nucala product FDA labeled for self-administration

☐ Patient has a history of uncontrolled disease and ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug

☐ The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.

☐ Patient has experienced severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Nucala within the past 6 months and requires administration and direct monitoring by a healthcare professional*

☐ Due to patient's weight, ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug

*Specific reactions: _____

## MEDICATION ORDERS:

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.

### DOSE/FREQUENCY:

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

**Administer as subcutaneous injection to the upper arm, thigh, or abdomen**

### SPECIAL ORDERS:

☐ _____

**Extended post treatment monitoring: monitor patient for one (1) hour after first injection, 30 minutes after second injection, and 15 minutes after each subsequent injection.**

☑ Refills x 12 months unless noted otherwise here:

## ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

## PRESCRIBER INFORMATION:

| | |
|---|---|
| PROVIDER NAME: | PHONE: |
| ADDRESS: | FAX: |
| CITY, STATE, ZIP: | NPI: |

| PRESCRIBER SIGNATURE: (No stamp signatures) | | DATE |
|---|---|---|
| | | |
| Dispense as written/Brand medically necessary | Substitution permitted | |