

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/>	<input type="checkbox"/> Order Renewal
Patient preferred clinic:			

Nucala® (mepolizumab) Standard Plan of Treatment for Hypereosinophilic Syndrome (HES)

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)

D72.119 - Hypereosinophilic syndrome (HES), unspecified
_____ - Other:

REQUESTED DOCUMENTATION:

1 Insurance information	IF NO:	IF YES:
2 Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3 Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4 Tried and failed therapies	FROM PREVIOUS	
5 Blood eosinophil level (pre-treatment baseline count greater than or equal to 150 cells/mcL)	THERAPY:	

IF ORDER CHANGE:	
Continue current order until insurance approved	

Provider Attestation for HCP administration:

<input type="checkbox"/> Provider attestation that the patient or caregiver are not competent or are physically unable to administer the Nucala product FDA labeled for self-administration	<input type="checkbox"/> 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*
<input type="checkbox"/> 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	<input type="checkbox"/> 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
<input type="checkbox"/> The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.	

*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) 300 mg every four (4) weeks via subcutaneous injection for the treatment of adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome (HES).

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 & ANAPHALAXIS 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)

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