

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

## Nucala® (mepolizumab) Pediatric (aged 6 to 11 years) Standard Plan of Treatment for Asthma

### 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:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

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

<input type="checkbox"/> J45.50 - Severe persistent asthma, uncomplicated
<input type="checkbox"/> J45.52 - Severe persistent asthma with status asthmaticus
<input type="checkbox"/> J45.51 - Severe persistent asthma with (acute) exacerbation
<input type="checkbox"/> _____ - Other:

### REQUESTED DOCUMENTATION:

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

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:	
			<b>Continue current order until insurance approved</b>

### 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) 40 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 & 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)

DATE

Dispense as written/Brand medically necessary	Substitution permitted



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)