

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

Nucala® (mepolizumab) Standard Plan of Treatment for EGPA

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 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

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

<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

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:

NURSING ORDERS:

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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)

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