ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Mepolizumab (Nucala):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

		ICD -10 Code:
Diagnosis:	❑ Severe persistent asthma	❑ J45.50
	❑ Pulmonary eosinophilia	❑ I82
	❑ Other_____	❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Was patient vaccinated for herpes zoster infection? ❑ Yes ❑ No
(May want to consider Zostavax vaccination in adults >50 years of age)

Baseline Lab Required:
- CBC with differential
- Absolute eosinophil count >0.015 K/uL within 6 weeks of initiation
- PFTs

Maintenance Labs Required:
- CBC with differential annually

Treatment Regimen:
Mepolizumab (Nucala) given SUBQ:
❑ 100 mg SUBQ every 4 weeks
❑ 300 mg SUBQ every 4 weeks

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):
- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
MEPOLIZUMAB (Nucala)

MultiCare

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