

# MHS Home/Alternate Site Infusion Services Mepolizumab (Nucala) Injection Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ lb/kg

Patient Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Requested Date of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Allergies: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD – 10 Code: \_\_\_\_\_

**Baseline Labs Required:**

- CBC w/ diff Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_
- Absolute eosinophil count >0.015 K/uL within 6 weeks of initiation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_
- PFTs Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_

**Maintenance Labs Required:**

CBC w/ diff every 12 months

\*Herpes zoster infection has occurred in patients receiving Mepolizumab (Nucala). Consider vaccination if medically appropriate.

**Additional Requirements:** In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. \*\* **Emergency phone number for provider** \_\_\_\_\_ (required) \*\*

## Provider Order for Mepolizumab (Nucala) Injection

ORDERS WITH CHECK  
BOXES

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

**Biologic Injection:**

Mepolizumab (Nucala) Dosing:

- 100 mg SUBQ every 4 weeks
- 300 mg SUBQ every 4 weeks

**Skilled Nurse to draw labs as follows:**

- CBC w/ diff every 12 months or other frequency \_\_\_\_\_

**Skilled Nurse Interventions:**

- Admit (first visit) patient to services for home infusion therapy of Mepolizumab (Nucala).
- Complete Skilled Nurse Visit with each injection for ongoing home infusion therapy of Mepolizumab (Nucala).
- Obtain vital signs (TPR & B/P) at baseline and post-injection.
- Obtain patient weight at each visit.
- Draw labs as ordered.
- Inject Mepolizumab (Nucala) as prescribed.
- If vital signs are stable after injection, Skilled Nurse will complete visit.

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FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

**Patient Identification:**

Name:  
MRN:  
DOB:

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**If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):**

The Skilled Nurse will:

- Administer emergency medications as prescribed (below).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

**Emergency Medications:** To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO<sub>2</sub>>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

**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)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

**Provider Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NPI:** \_\_\_\_\_ **Orders expire in 12 months unless otherwise specified:** \_\_\_\_\_

**Provider/Clinic Information:**

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**Return completed orders to:**

MultiCare Home/Alternate Infusion Services  
253-459-6650 (phone) / 253-864-2785 (fax)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

**Patient Identification:**

Name:  
MRN:  
DOB:

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