

(mepolizumab)

NUCALA Infusion Orders



Patient Name _____ DOB _____ Gender: M F

Phone _____

DIAGNOSIS: *Please provide IDC-10 Code*

- _____ Severe Allergic Asthma with Eosinophilic Phenotype. 12yo
- _____ Adult Eosinophilic Granulomatosis with Polyangiitis (EGPA)
- _____ (Other)

PRE-MEDICATION:

- | | |
|--|---|
| <input type="checkbox"/> Tylenol 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> _____ Other | <input type="checkbox"/> _____ Other |

NUCALA ORDERS:

DOSAGE

- 100mg SQ every 4 weeks
- 300mg SQ as separate 100mg injections every 4 weeks
- Emergency Orders and Treatment per Specialty Infusion Center Anaphylaxis Policy**

PATIENT WEIGHT

_____ LBS
_____ KG

NOTES:

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Administer injection as ordered

ORDERING PROVIDER:

Signature _____ Printed Name: _____ Date _____

Practice _____ Phone _____ Fax _____

*****PLEASE FAX COMPLETED ORDER TO SPECIALTY INFUSION CENTER 231-600-7058*****
