

Nucala (Mepolizumab) Referral Form



REQUIRED INFORMATION

- ☐ This signed order form from the provider
- ☐ Patient demographics and insurance information
- ☐ Clinical/Progress Notes, Labs (including CBC w/differential) and Tests supporting primary diagnosis (ICD-10 below)
- ☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	
Diagnosis: ☐ Severe Allergic Asthma with eosinophilic phenotype (ICD-10 _____) Dose: ☐ Nucala 100 mg subcutaneously every 4 weeks Refill: ☐ PRN x 1 year OR _____ times		
Diagnosis: ☐ Eosinophilic Granulomatosis with Polyangiitis (ICD-10 _____) Dose: ☐ Nucala 300 mg subcutaneously every 4 weeks Refill: ☐ PRN x 1 year OR _____ times		
Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician Labs: _____ Frequency: _____		
Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed		
Nursing Orders: ☐ Pharmacy to provide nursing services for initial administration and teaching and as needed ☐ May use Burnham's Vital Care anaphylaxis protocol as needed		
Additional Instructions:		
Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		

ALABAMA

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MISSISSIPPI

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