Phone: (805) 719-3700
Fax: (805) 413- 9099
Website: infusionforhealth.com

NUCALA INJECTION ORDER

Please fax a copy of patient's:

- □ **Demographics**
- □ **Current Lab Results**
- □ **Eosinophil Level**
- □ **Copy of Insurance Cards**
- □ **H & P Relevant to Diagnosis**
- □ **Medication List Including High Dose ICS**

Date: ____/____/____

Patient Name: ____ **DOB:** ____/____/____

Allergies: ____ **Wt:** ______ **lbs / kg** **Ht:**__________

Diagnosis: ____ **ICD 10:** ______________________

Nucala (mepolizumab)

100 mg subcutaneous Q 4 weeks

Exacerbation History 2 or more in prior 12 months:____________________________

Blood eosinophil level must be ≥150 cells/ml : __________

**** PER OUR PROTOCOL, ALL PATIENTS MUST HAVE EPINEPHRINE AUTO INJECTOR WITH THEM AT TIME OF INJECTION.**
PATIENT WILL BE MONITORED FOR 30 MINUTES

Printed Provider's Name: ____ **NPI:** ____________________

Provider's Signature: ____ **Date:**_____/_____/_____

Office Phone Number: ______________________________ **Office Fax:**______________________________

Office Address: ____**Contact Person:** _________________