Nucala Injection Order

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ____ / ____ / ____ Treatment Location: _____

***Please fax a copy of the following patient information:**

- ☐ Demographics
- ☐ Insurance Information
- ☐ Current Lab Results
- ☐ H & P Relevant to the Diagnosis
- ☐ Eosinophil Level
- ☐ Medication List Including High Dose ICS

PATIENT INFORMATION

Patient Name: _____

DOB: ____ / ____ / ____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____ / ____ / ____

Phone: (____) ____ - ____ Fax: (____) ____ - ____

Office Address: _____

Contact Person: _____

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 INFECTOR WITH THEM AT TIME OF INJECTION. Patient will be monitored for 30 minutes.**