LIFEBRIDGE HEALTH
CARE BRAVELY

MEPOLIZUMAB (Nucala®) ORDER FORM

Patient Label

Date: _____

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

Pre-appointment Documentation:

Please fax most recent office visit note documenting the patient's diagnosis as well as a copy of the patient's demographic information along with this order form.

Treatment:

Adults

☐ Mepolizumab (Nucala®) 100mg subcutaneously every 4 weeks

Duration of therapy (1 year unless otherwise specified): _____

☐ Mepolizumab (Nucala®) 300mg subcutaneously every 4 weeks

Duration of therapy (1 year unless otherwise specified): _____

Pediatrics

Children 6 to 11 years

☐ Mepolizumab (Nucala®) 40mg subcutaneously every 4 weeks

Duration of therapy (1 year unless otherwise specified): _____

Children ≥ 12 years

☐ Mepolizumab (Nucala®) 100mg subcutaneously every 4 weeks

Duration of therapy (1 year unless otherwise specified): _____

☐ Mepolizumab (Nucala®) 300mg subcutaneously every 4 weeks

Duration of therapy (1 year unless otherwise specified): _____

☒ **Hypersensitivity/Anaphylaxis Medications and Extravasation Management (PRN):** Follow Adult Hypersensitivity Protocol as needed per Nursing Protocol for the treatment of allergic/hypersensitivity reaction. Follow established hospital protocol for extravasation.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

SINAI HOSPITAL
FAX TO: 410-601-4452
410-601-9311
PHONE: 410-601-4779

NORTHWEST HOSPITAL
FAX TO: 410-521-7385
410-521-8889
PHONE: 410-521-8393

Wm. E. KAHLERT CANCER CENTER (CARROLL HOSPITAL)
FAX TO: 410-871-6521
PHONE: 410-871-6400