LIFEBRIDGE HEALTH
CARE BRAVELY

MEPOLIZUMAB (Nucala®)
ORDER FORM

Patient Name: _____ DOB: _____

Allergies: _____ Height (cm) : _____ Weight (kg) : _____

Diagnosis: _____ Diagnosis Code: _____

Diagnosis: _____ Diagnosis Code: _____

Diagnosis: _____ Diagnosis Code: _____

Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.

- ☐ Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- ☐ Demographics / insurance information attached, or available in Cerner.
- ☐ Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: _____

Treatment:

****Will assume 1 year duration of therapy unless otherwise specified.****

Adults

- ☐ Mepolizumab (Nucala®) 100 mg subcutaneously every 4 weeks. Duration of therapy: _____
- ☐ Mepolizumab (Nucala®) 300 mg subcutaneously every 4 weeks. Duration of therapy: _____

Pediatrics

Children 6 to 11 years

- ☐ Mepolizumab (Nucala®) 40 mg subcutaneously every 4 weeks. Duration of therapy: _____

Children ≥ 12 years

- ☐ Mepolizumab (Nucala®) 100 mg subcutaneously every 4 weeks. Duration of therapy: _____
- ☐ Mepolizumab (Nucala®) 300 mg subcutaneously every 4 weeks. Duration of therapy: _____

Protocol Orders:

☒ Hypersensitivity/Anaphylaxis Medications: Follow Adult Hypersensitivity Nursing Protocol PRN for the treatment of allergic/hypersensitivity reaction.

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

Contact Number: _____ Fax Number: _____

ALVIN & LOIS LAPIDUS CANCER CENTER
(SINAI HOSPITAL)
FAX: 410-601-4452
PHONE: 410-601-4779

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