

PRESCRIPTION ORDER FORM



NUCALA

(mepolizumab)

Central Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- Progress Note
- Demographics

PRIMARY DIAGNOSIS

- Severe asthma (age 6+)
- ☐ J45.50 ☐ J45.52 ☐ J45.51
- ☐ D72.119 Hypereosinophilic syndrome
- ☐ J33.8 Chronic rhinosinusitis w/ nasal polyps
- ☐ M30.1 Eosinophilic granulomatosis w/ polyangiitis
- ☐ J44 COPD
- ☐ Other: _____

CLINICAL MONITORING

Consider completing all age-appropriate vaccinations as recommended by current immunization guidelines

PRIMARY MEDICATION ORDER ** If necessary, Suite Life will round dose up/down according to payor guidelines**

- Severe asthma in patients aged 12 years and older: 100 mg administered subcutaneously once every 4 weeks
- ☐ CRSwNP: 100 mg administered subcutaneously once every 4 weeks.
- ☐ COPD: 100 mg administered subcutaneously once every 4 weeks.
- ☐ EGPA: 300 mg administered subcutaneously once every 4 weeks.

LINE USE/CARE ORDERS

- ☒ Start PIV/ACCESS CVC ☒ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol
(See suitelifehealth.com for detailed policy)
- ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date

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