Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Nucala Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Severe persistent asthma, uncomplicated ICD-10: J45.50
- ☐ Severe persistent asthma with acute exacerbation ICD-10: J45.51
- ☐ Eosinophilic Granulomatosis with Polyangiitis (EGPA) ICD-10: M30.1
- ☐ Hypereosinophilic Syndrome (HES) ICD-10: D72.11
- ☐ Eosinophilic Asthma (ICD-10 code: J82.83)
- ☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) ICD-10: _____
- ☐ Other ICD-10: _____

ORDER FOR NUCALA (MEPOLIZUMAB):

- ☐ Nucala **100mg** subcutaneously every 4 weeks x 1 year
- ☐ Nucala **300mg** subcutaneously every 4 weeks x 1 year

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Please indicate any tried and failed therapies (if applicable):

- ☐ Corticosteroids _____
- ☐ Long-acting beta 2 agonist _____
- ☐ Long-acting muscarinic antagonist _____
- ☐ Immunosuppressants (EGPA) _____

☐ Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period?

☐ Yes OR ☐ No

☐ Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120 (asthma)?

☐ Yes OR ☐ No

☐ Include labs and/or test results to support diagnosis

☐ Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks (asthma & EGPA) or ≥ 1000 cells/mcL within 4 weeks (HES) ?

☐ Yes OR ☐ No (please attach CBC)

☐ FEV1 score (if applicable): _____

☐ Is the patient or caregiver able to administer Nucala for self-administration?

☐ Yes OR ☐ No

If no, please state reason: _____

☐ Other medical necessity: _____

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Revised 04/25