NUCALA
(mepolizumab)

FLEXCARE INFUSION CENTERS

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
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Initial Requests: Eosinophil Count

- Renewal Requests: Did the patient experience measurable evidence of improvement in disease activity and/or severity? ☐ Y ☐ N (provide documentation)

PRIMARY DIAGNOSIS

☐ J33.0 Nasal polyps
☐ J44.9 Chronic obstructive pulmonary disease
☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.41 Severe persistent asthma with (acute) exacerbation
☐ J82.83 Eosinophilic asthma
☐ M30.1 Eosinophilic granulomatosis with polyangiitis (EGPA)
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Nucala
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Asthma (COPD, Rhinosinusitis)
☐ Nucala 100mg subQ every 4 weeks
☐ Other: _____

EGPA, Hypereosinophilic syndrome
☐ Nucala 300mg (three 100mg injections) subQ every 4 weeks
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.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 _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

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