Mepolizumab (Nucala)

Provider Order Form rev. 12/23/2021

AleraCare
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PATIENT INFORMATION

Patient Name:		DOB:
☐ NKDA Allergies:		Weight lbs/kg:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

ICD-10 CODE

☐ J45.50 Severe asthma and with an eosinophilic phenotype

☐ J33. 9 chronic rhinosinusitis with nasal polyps

☐ M30.1 eosinophilic granulomatosis with polyangiitis

☐ D72.119 hypereosinophilic syndrome

☐ Other: _____

SPECIAL INSTRUCTIONS

MEDICATION ORDER

☑ Mepolizumab (**Nucala**)
- Dose: ☐ 100mg / ☐ 300mg
- Route: subcutaneous injection
- Frequency: ☐ every 4 weeks / ☐ other: _____

☑ Patient is required to stay for 30 minutes observation post injection

☑ Patient is NOT required to stay for observation

☑ Refills: ☐ Zero / ☐ for 12 months / ☐ _____(if not indicated order will expire one year from date signed)

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months