Mepolizumab (Nucala)

Provider Order Form rev. 10/21/2026

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Severe Persistent Asthma:	EGPA:
Hypereosinophilic syndrome (HES):	Chronic rhinosinusitis with nasal polyps (CRSwNP):
Other:	Description:

THERAPY ADMINISTRATION & DOSING

☑ One-hour post-injection observation period mandatory for first 3 injections. 30 min observation period mandatory for all subsequent visits.

For Severe Asthma/CRSwNP:

☐ Administer Mepolizumab (Nucala) 100mg subcutaneously once every 4 weeks.

For EGPA/HES:

☐ Administer Mepolizumab (Nucala) 300mg as three separate 100mg injections subcutaneously once every 4 weeks.

☑ Divide doses exceeding 100 mg with multiple sites to limit injections to no more than 100 mg per site.

Anaphylaxis Prevention: (Recommended)

☐ Patient has an EpiPen.

☐ Rx for EpiPen has been sent to retail pharmacy.

☐ Patient does not require EpiPen for this therapy.

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- current parasitic infection
- signs/symptoms of active infections or difficulty breathing

☑ If indicated as required by provider, confirm patient has epinephrine auto-injector and understands indications for use.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Spirometry results, Pulmonary function test, hospitalizations, and flares

Required Labs: Skin test, IgE

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.