



**General**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Phone # \_\_\_\_\_

Order Start Date \_\_\_\_\_ Order Expiration Date (max one year) \_\_\_\_\_

Allergies: \_\_\_\_\_

**Guidelines for Ordering:**

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with mepolizumab. Decrease corticosteroids gradually, if appropriate.
3. Herpes zoster infections have occurred in patients receiving mepolizumab. Consider varicella vaccination if medically appropriate prior to starting therapy with mepolizumab.
4. Treat patients with pre-existing helminth infections before therapy with mepolizumab. If patients become infected while receiving treatment with mepolizumab and do not respond to anti-helminth treatment, discontinue mepolizumab until parasitic infection resolves.

**DIAGNOSIS CODE:**

- J45.50 Severe persistent asthma, uncomplicated  Other: \_\_\_\_\_
- M30.1 EGPA (eosinophilic granulomatosis with polyangiitis)

**Nursing Orders**

Vital Signs: baseline and at discharge. Hold patient for 15 minutes post-administration to observe/monitor for adverse reaction

**Medication Orders**

**Asthma**

mepolizumab (Nucala) 100mg/1mL by subcutaneous route every 4 weeks for \_\_\_\_\_ total doses.

**EGPA**

mepolizumab (Nucala) 300mg by subcutaneous route (administer as three separate 100mg injections at a distance of 5cm or more apart) every 4 weeks for \_\_\_\_\_ total doses.

**IF HYPERSENSITIVITY OR ANAPHYLACTIC REACTION OCCURS**

Notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

<p><i>Patient Name:</i></p> <p><i>DOB:</i></p>
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**Ordering Facility/Provider Information**

**By signing below, I affirm the following:**

I am responsible for the care of the patient identified on this form.

I hold an active, unrestricted license to practice medicine in \_\_\_\_\_ (*specify state*)

My physician license number is # \_\_\_\_\_ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

<b>Provider Signature:</b> _____	<b>Date</b> _____
<b>Printed name:</b> _____	<b>Phone:</b> _____ <b>Fax:</b> _____

<b>KVH Provider Co-signature:</b> <i>*Required for all external orders</i>	
<b>Provider Signature:</b> _____	<b>Date</b> _____
<b>Printed name:</b> _____	

<i>Patient Name:</i>
<i>DOB:</i>