- ☐ *Borough Park* 1428 36th Street, Suite 107, Brooklyn, NY 11218
- ☐ *Crown Heights* 555 Lefferts Avenue, Brooklyn, NY 11225
- ☐ *Manhattan* 57W 57Street, Suite 601, New York, NY 10019
- ☐ *Manhasset* 333 East Shore Road, Suite 201, Manhasset, NY 11030
- ☐ *Rockville Centre* 165 North Village Avenue, Suite 133, Rockville Center, NY 11570
- ☐ *Elmsford/ Terrytown* 555 Taxter Road, 3rd Floor, Elmsford, NY 10523

Office: 212-803-3339 Fax : 646-768-8600

- ☐ *Manhattan* 225 E 70th Street, Suite 1E, New York, NY 10021
- ☐ *Queens* 64-05 Yellowstone Blvd, CF104, Forest Hills, NY 11375
- ☐ *Manhattan* 225 East 70th Street, New York, NY 10021
- ☐ *Holbrook/ Ronkonkoma* 233 Union Ave, Suite 207, Holbrook, NY 11741
- ☐ *Scarsdale* 495 Central Park Avenue, Suite 205, Scarsdale, NY 10583
- ☐ *5 Towns* 141 Washington Avenue, Cedarhurst, NY 11559
- ☐ *Long Beach* 917 Beech Street, Long Beach, NY 11561
- ☐ *Riverhead* 1228 E Main Street, Suite A, Riverhead, NY 11901

(mepolizumab)

NUCALA infusion orders

Date: ________________

Patient Name ______________________________________ DOB ____________

Phone ______________________________ M ○ F ○

REFERRAL STATUS ○ Allergies:____________

☐ New Referral ☐ Medication/Order Change ☐ Discontinuation Order
☐ Referral Renewal ☐ Benefits Verification Only

DIAGNOSIS *Please provide ICD-10 code*

☐ __________ Severe Allergic Asthma with Eosiniphilic Phenotype > 12 yro
☐ __________ Adult Eosinophilic Granulomatosis with Polyangiitis (EGPA)
☐ __________ ______________________________________ *(other)*

PER-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ ______________________________ *(other)*

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ ______________________________ *(other)*

NUCALA ORDERS

DOSAGE

◉ 1,000u SQ, every 4 weeks
○ 300mg SQ as separate 100mg injections, every 4 weeks
○ Other

PATIENT WEIGHT

__________ lbs.
__________ kg

TOTAL DOSES: 1 yr ________ Other__________ Refill__________

NOTES

____

ORDERING PROVIDER

Signature **X** ____ Date ____________

Provider ________________________ Phone __________ Fax ____________