*Chicago Illinois*
4711 Golf Road
Suite 900
Skokie, IL 60076

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

REJUVEINATE

**(mepolizumab)**

# NUCALA

Infusion orders

*Date:* _____

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | DOB: | SEX: M ☐ F ☐ |
| ICD-10 code (required): | ICD-10 description: | |
| ☐NKDA Allergies: | | Weight lbs/kg: |

## REFERRAL STATUS

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

## PHYSICIAN INFORMATION

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

### DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Severe Allergic Asthma with Eosiniphilic Phenotype > 12 yro
- ☐ _____ Adult Eosinophilic Granulomatosis with Polyangiitis ( EGPA)
- ☐ _____ _____

### PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

### SPECIAL INSTRUCTIONS

### NUCALA ORDERS

- ☐ 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/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____