Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Nucala® (mepolizumab) Pediatric (aged 6 to 11 years) Standard Plan of Treatment for Asthma

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight: LB or KG			Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ J45.50 - Severe persistent asthma, uncomplicated
- ☐ J45.52 - Severe persistent asthma with status asthmaticus
- ☐ J45.51 - Severe persistent asthma with (acute) exacerbation
- ☐ _____ - Other:

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:
2	Most recent History & Physical	
3	Full medication list	
4	Tried and failed therapies	
5	Blood eosinophil level (pre-treatment baseline count greater than or equal to 150 cells/mcL)	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF YES:

LAST INJECTION DATE:

NEXT INJECTION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

Provider Attestation for HCP administration:

- ☐ Provider attestation that the patient or caregiver are not competent or are physically unable to administer the Nucala product FDA labeled for self-administration
- ☐ Patient has a history of uncontrolled disease and ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug
- ☐ The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.
- ☐ Patient has experienced severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Nucala within the past 6 months and requires administration and direct monitoring by a healthcare professional*
- ☐ Due to patient's weight, ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug

*Specific reactions: _____

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive Nucala® (mepolizumab) if patient has signs/symptoms of parasitic infection, is currently being treated for a parasitic infection, or is having acute bronchospasm and/or asthma attack.

DOSE/FREQUENCY:

☑ Nucala® (mepolizumab) 40 mg every four (4) weeks via subcutaneous injection

Administer as subcutaneous injection to the upper arm, thigh, or abdomen.

SPECIAL ORDERS:

☐ _____

Extended post treatment monitoring: monitor patient for one (1) hour after first injection, 30 minutes after second injection, and 15 minutes after each subsequent injection.

☑ Refills x 12 months unless noted otherwise here:

ADVERSE REACTION & ANAPHALAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	