



Clearwater: Phone: 727.977.9717 | Fax: 727.977.9717  
Tampa: Phone: 813.775.9997 | Fax: 813.775.9997  
Email: intake@sageinfusion.com | Online: www.sageinfusion.com

(mepolizumab)

# NUCALA infusion orders

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
Phone \_\_\_\_\_ M O F O

### DIAGNOSIS Please provide ICD-10 code

- \_\_\_\_\_ Severe Allergic Asthma with Eosinophilic Phenotype > 12 yro
- \_\_\_\_\_ Adult Eosinophilic Granulomatosis with Polyangiitis (EGPA)
- \_\_\_\_\_ \_\_\_\_\_  
(other)

### PRE-MEDICATION

- |  |  |
|--|--|
| <input type="checkbox"/> Tylenol 1000mg PO   | <input type="checkbox"/> Solu-Medrol 125mg IVP   |
| <input type="checkbox"/> Diphenhydramine 25mg PO   | <input type="checkbox"/> Solu-Cortef 100mg IVP   |
| <input type="checkbox"/> Cetirizine 10mg PO  | <input type="checkbox"/> Diphenhydramine 25mg IVP  |
| <input type="checkbox"/> _____<br><span style="display: block; text-align: right;"><small>(other)</small></span> | <input type="checkbox"/> _____<br><span style="display: block; text-align: right;"><small>(other)</small></span> |

### NUCALA ORDERS

| DOSAGE   | PATIENT WEIGHT |
|--|----------------|
| <input checked="" type="radio"/> 100mg SQ, every 4 weeks                   | _____ lbs.     |
| <input type="radio"/> 300mg SQ as separate 100mg injections, every 4 weeks | _____ kg       |

### NOTES

### ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_