Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

INFUSE ONE

(mepolizumab)

NUCALA infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Severe Allergic Asthma with Eosinophilic Phenotype > 12

☐ _____ yro Adult Eosinophilic Granulomatosis with Polyangiitis

☐ _____ (_____)
(other)

PRE-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	PATIENT WEIGHT
☑ 100mg SQ, every 4 weeks	_____ lbs.
☐ 300mg SQ as separate 100mg injections, every 4 weeks	_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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