

ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER

ALLERGIES/REACTIONS (REQUIRED):

Yakima Outpatient Infusion Care
808 N 39th Ave Yakima WA 98902
Phone: 509-575-1174
Fax: 509-577-5021

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

CODE STATUS

Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

MEPOLIZUMAB (NUCALA)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg Patient Height: \_\_\_\_\_

DIAGNOSIS & ICD-10 CODE (REQUIRED):

- Asthma, severe eosinophilic (ICD-10: \_\_\_\_\_)
Eosinophilic granulomatosis with polyangiitis (ICD-10: \_\_\_\_\_)
Hypereosinophilic syndrome (ICD-10: \_\_\_\_\_)
Rhinosinusitis with nasal polyps (ICD-10: \_\_\_\_\_)
Other: \_\_\_\_\_ (ICD-10: \_\_\_\_\_)

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

\*\*If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available\*\*

TREATMENT REGIMEN: (another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)

MEPOLIZUMAB SUBCUTANEOUS INJECTION

- 100 mg Sub-Q injection every 4 weeks
300 mg Sub-Q injection every 4 weeks

LENGTH OF THERAPY: 1 Year (Maximum/Default) 6 months Other: \_\_\_\_\_

ADDITIONAL INFORMATION/MONITORING: \_\_\_\_\_

SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after injection when vital signs are stable, and no reaction is present. If no injection-related events with previous 3 doses, may waive post-monitoring period and discharge home after completion.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

NEW REFERRAL UPDATED REFERRAL

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Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

MEPOLIZUMAB (Nucala)



Yakima Memorial Hospital