Mepolizumab (Nucala)

Provider Order Form rev. 10/21/2026

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Severe Persistent Asthma:	EGPA:
Hypereosinophilic syndrome (HES):	Chronic rhinosinusitis with nasal polyps (CRSwNP):
Other:	Description:

THERAPY ADMINISTRATION & DOSING

☑ One-hour post-injection observation period mandatory for first 3 injections. 30 min observation period mandatory for all subsequent visits.

For Severe Asthma/CRSwNP:

☐ Administer Mepolizumab (Nucala) 100mg subcutaneously once every 4 weeks.

For EGPA/HES:

☐ Administer Mepolizumab (Nucala) 300mg as three separate 100mg injections subcutaneously once every 4 weeks.

☑ Divide doses exceeding 100 mg with multiple sites to limit injections to no more than 100 mg per site.

Anaphylaxis Prevention: (Recommended)

☐ Patient has an EpiPen to be used for this therapy.

☐ Rx for EpiPen has been sent to retail pharmacy.

☐ Patient does not require EpiPen for this therapy.

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- current parasitic infection
- signs/symptoms of active infections or difficulty breathing

☑ If indicated as required by provider, confirm patient has epinephrine auto-injector and understands indications for use.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name:		Preferred Contact Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Spirometry results, Pulmonary function test, hospitalizations, and flares

Required Labs: Skin test, IgE

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.