Rutland Regional Medical Center
www.RRMC.org | 160 Allen Street, Rutland, VT | 802.775.7111

Mepolizumab (Nucala®)

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (kg): Height (cm):

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

Insurance carrier: PA #: PA date:

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

☐ Severe Persistent Asthma: ☐ Eosinophilic granulomatosis with polyangiitis (EGPA):

☐ Hypereosinophilic syndrome (HES): ☐ Chronic rhinosinusitis with nasal polyps (CRSwNP):

☐ Other: Description:

THERAPY ADMINISTRATION & DOSING

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.

ADDITIONAL ORDERS

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 and post- procedure observation per policy

☐ In the event of an infusion reaction, per RRMC Infusion Reaction Management policy, the patient may receive:
- Acetaminophen 1000 mg orally
- Epinephrine 0.5 mg IM
- Diphenhydramine 25-50 mg IV push
- Normal saline IV at 150 mL/hr
- Methylprednisolone 125 mg IV push

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: CRP/ESR

Provider Name *(print)* **Provider Signature** **Time** **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

Form #5508 created 8/2025

White- Patient
Yellow- Medical Records

Patient Label