



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

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Nucala (mepolizumab) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ Height (inches): _____ Weight (lbs): _____

3. Diagnosis:

- J45.50 severe persistent asthma, uncomplicated
- J45.51 severe persistent asthma with (acute) exacerbation
- J45.52 severe persistent asthma with status asthmaticus
- Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications:

- Acetaminophen:
 - 1000mg PO 500mg PO
- Diphenhydramine:
 - 25mg PO 50mg PO 25mg IV 50mg IV
- Hydrocortisone: 100mg IVP
- Other Pre-medication: _____
- No Pre-medications indicated

5. Drug Order:

- Nucala (mepolizumab)** *Ok to substitute with generic/biosimilar*
- 100mg subcutaneous injection (to upper arm, thigh or abdomen) every 4 weeks
- Other: _____
- Special Instructions: _____
- New to Therapy
- Continuing Therapy, Last dose received _____ Next dose due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

- Other: _____
- No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.

The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Required Baseline Lab/Testing completed:

- Blood Eosinophil Level (Pre-treatment baseline count greater than or equal to 150 cells/mcL), date: _____
(Absolute Eosinophil in K/ μ L x 1000 = cells/mcL)

8. Patient Assistance & REMS Program Enrollment

- Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
- No, patient has not been enrolled in any programs.

7. Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

(This drug administration order form is valid for 12 months)