



MONTGOMERY
CANCER CENTER

A BAPTIST MEDICAL CENTER SOUTH FACILITY

MEDICATION ORDERS

NUCALA (MEPOLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency	<input type="checkbox"/> Change Order Renewal

INFUSION OFFICE PREFERENCE (Optional)	
Preferred Location:	<input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Severe Uncontrolled Asthma with Eosinophilic Phenotype ICD 10 Code: J45.50 → Does the patient have current blood eosinophil counts \geq 150 cells/ μ L? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Eosinophilic Granulomatosis with Polyangiitis (EGPA) ICD 10 Code: M30.1 → Has the patient relapsed or been refractory to standard of care therapy, including oral steroids? <input type="checkbox"/> YES <input type="checkbox"/> NO	

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis including blood eosinophil counts
<input type="checkbox"/> Pulmonary Function Tests (if asthma)	
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	

MEDICATION ORDERS	
Dosing for Severe Asthma with Eosinophilic Phenotype	<input type="checkbox"/> Nucala 100mg subQ every 4 weeks
Dosing for EGPA	<input type="checkbox"/> Nucala 300mg subQ every 4 weeks
Refills: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses	
<ul style="list-style-type: none"> New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines. Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication. 	

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207