

# Mepolizumab (Nucala)

## Provider Order Form

### PATIENT INFORMATION

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Date:	Patient Name:	DOB:
ICD-10 code (required):		ICD-10 description:
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
<b>Patient Status:</b> <input type="checkbox"/> New to Therapy	<input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):

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### PROVIDER INFORMATION

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

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### NURSING

- Provide nursing care per IVX Standard Nursing Procedures, including reaction management and post-infusion observation

### SPECIAL INSTRUCTIONS

### THERAPY ADMINISTRATION

- Mepolizumab (Nucala)
- Dose:  100mg /  300mg
  - Route: subcutaneous injection
  - Frequency:  every 4 weeks /  other: \_\_\_\_\_
- Patient is required to stay for 30 minutes observation post injection
- Patient is NOT required to stay for observation
- Refills:  Zero /  for 12 months /  \_\_\_\_\_ (if not indicated order will expire one year from date signed)

**Ordering Provider: Initial here \_\_\_\_\_ and proceed to the next page.**

## ADULT REACTION MANAGEMENT PROTOCOL

- Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting
- If reaction occurs:
- Stop infusion.
  - Maintain/establish vascular access.
  - Notify referring provider as clinically appropriate and follow clinical escalation protocol.
  - IVX Health clinicians have the following PRN medications available for the following reactions.
    - Headache, pain, fever > 100.4F, chills or rigors- Acetaminophen 650mg PO or Ibuprofen 400mg PO.
    - Mild Hives, itching, redness, or rash- Loratadine 10mg PO or Diphenhydramine 50mg PO.
    - Severe hives, itching, redness, or rash- Diphenhydramine 25-50mg SIVP.
    - Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg ODT (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg PO.
    - Severe Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg SIVP (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg SIVP.
    - Hypotension (90/60), vasovagal response- Place patient in reclined position, administer 0.9% Sodium Chloride IV 250ml. May repeat to keep BP >90/60, maximum of 1000ml, monitor vital signs.
    - Chest pain/discomfort, shortness of breath- Oxygen 2-15 liters, titrate to keep Spo2 >92%.
    - Solumedrol 125mg IV- Refractory to other treatments given.
    - Other \_\_\_\_\_
  - When symptoms resolve resume infusion at 50% previous rate and increase per manufactures guidelines.
- Severe allergic/anaphylactic reaction:**
- If symptoms are rapidly progressing or continuing after administration of PRN medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
    - Call 911.
    - Initiate basic life support as needed.
    - Bring the **AED** to the patient (Attach pads if indicated).
    - **Epinephrine**- administer 0.3mg of a 1:1,000 (1mg/ml) concentration intramuscularly (preferably outer thigh), may be repeated every 5-15 minutes as needed to a maximum of 3 doses.
    - Place patient in recumbent position, elevate lower extremities.
    - **Oxygen**- administer 2-15 liters/minute or 100 percent oxygen as needed maintain SpO2 >92 percent.
    - **IV Fluids**- Treat hypotension with normal saline bolus of 500ml, repeat as needed to maintain systolic BP >90.
    - Administer **diphenhydramine** 50mg IV or Famotidine 20mg IVP, if not previously given.
    - Administer **methylprednisolone** 125mg IVP, if not previously given.
    - Continuous monitoring of blood pressure, pulse oximetry, and heart rate.
    - Notify clinical executive, DON or CMO, when appropriate. Must be done same day. Do not delay treatment.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Provider Name (Print)**

\_\_\_\_\_  
**Provider Signature**

\_\_\_\_\_  
**Date**

**Email [ivxintake@ivxhealth.com](mailto:ivxintake@ivxhealth.com) or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:**

**CHICAGO: 312-253-7244** \_\_\_Glenview \_\_\_Schaumburg \_\_\_Lombard \_\_\_Naperville

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