MIC | METRO INFUSION CENTER

MEDICATION ORDERS- NUCALA (MEPOLIZUMAB)

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

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
☐ Severe Uncontrolled Asthma with Eosinophilic Phenotype ICD 10 Code: J45.50
→ Does the patient have current blood eosinophil counts ≥ 150 cells/µL? ☐ YES ☐ NO
☐ Eosinophilic Granulomatosis with Polyangitis (EGPA) ICD 10 Code: M30.1
→ Has the patient relapsed or been refractory to standard of care therapy, including oral steroids? ☐YES ☐ NO

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information ☐ Pulmonary Function Tests (if asthma)	☐ Clinical/Progress notes ☐ Labs and Tests supporting primary diagnosis, including blood eosinophil counts
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Dosing for Severe Asthma with Eosinophilic Phenotype	☐ Nucala 100mg subQ every 4 weeks
Dosing for EGPA	☐ Nucala 300mg subQ every 4 weeks
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164