



Trinity Health Muskegon & Shelby Infusion Clinics

Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444

Shelby: 72 S. State St. Shelby, MI 49455

Fax (shared): 231-672-3970

Mepolizumab (NUCALA®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: ____/____/____

Site of Service: TH Muskegon TH Shelby

Referral Status: New Referral Dose or Frequency Change Renewal

Patient Name: _____ Date of Birth: ____/____/____ Weight: ____ kg Height: ____ cm Allergies: _____	Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____
<p style="text-align: center;">Diagnosis</p> Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	<p style="text-align: center;">Lab Orders</p> <p style="text-align: center;">No labs required. Labs to be ordered by physician.</p> <input type="checkbox"/> Other: _____
Pre-Medications: No routine pre-medications indicated. <input type="checkbox"/> Other: _____	
Hold and notify provider: if patient presents with acute uncontrolled asthma exacerbation OR signs/symptoms of herpes zoster infection.	
<p style="text-align: center;">Mepolizumab (NUCALA®) 100 mg/ml prefilled syringe</p> <p>R_x <input type="checkbox"/> 100 mg <input type="checkbox"/> 300mg</p> Administer via subcutaneous injection (into the upper arm, thigh, or abdomen) once. Repeat every 4 weeks	
<p>Nursing Orders</p> Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary. sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN	
Provider Name: _____ Office Phone Number: _____ Attending Physician Name: _____ <i>(If ordering provider is an advanced practice practitioner, attending physician required)</i> <i>Note: This order is valid for 12 months from date of physician signature.</i>	Provider Signature: _____ Office Fax Number: _____