St. Charles Health System Adult Ambulatory Infusion Order Mepolizumab (NUCALA)	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING

1. Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with mepolizumab. Decrease corticosteroids gradually, if appropriate.
2. Herpes zoster infections have occurred in patients receiving mepolizumab. Consider varicella vaccination if medically appropriate prior to starting therapy with mepolizumab.
3. Treat patients with pre-existing helminth infections before therapy with mepolizumab. If patients become infected while receiving treatment with mepolizumab and do not respond to anti-helminth treatment, discontinue mepolizumab until parasitic infection resolves.

NURSING ORDERS:

1. Administer subcutaneously into the upper arm, thigh, or abdomen. Do not inject into skin that is tender, bruised, red, or hard.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
3. Observe patient for hypersensitivity reactions, including anaphylaxis, for 30 minutes after administration.

MEDICATIONS:

1. **Select one of the following dosing schedules:**

☐	Inject mepolizumab 100 mg subcutaneously every 4 weeks
☐	Inject mepolizumab 300 mg (administer as THREE separate 100 mg injections at a distance 5 cm or more apart) subcutaneously every 4 weeks
☐	Other_____

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction

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3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:
_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed