CURBSIDE INFUSION SERVICES

Fax To: 281-406-1047
Email To: referrals@curbsideinfusion.com
Office: 281-406-1046

NUCALA (mepolizumab) infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Severe Allergic Asthma with Eosinophilic Phenotype > 12
- ☐ _____ yro Adult Eosinophilic Granulomatosis with Polyangiitis
- ☐ _____ (EGPA) _____
  (other)

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ Quzyttir 10mg IVSP over 1-2 min
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____
  (other)

NUCALA ORDERS

DOSAGE

- ◉ 100mg SQ, every 4 weeks
- ○ 300mg SQ as separate 100mg injections, every 4 weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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