Outpatient Nucala Order Set

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with mepolizumab. Decrease corticosteroids gradually, if appropriate.
3. Herpes zoster infections have occurred in patients receiving mepolizumab. Consider varicella vaccination if medically appropriate prior to starting therapy with mepolizumab.
4. 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.

DIAGNOSIS CODE:

☐ J45.50 Severe persistent asthma, uncomplicated ☐ Other: _____

☐ M30.1 EGPA (eosinophilic granulomatosis with polyangiitis)

Nursing Orders

☒ Vital Signs: baseline and at discharge. Hold patient for 15 minutes post-administration to observe/monitor for adverse reaction

Medication Orders

Asthma

☐ mepolizumab (Nucala) 100mg/1mL by subcutaneous route every 4 weeks for _____ total doses.

EGPA

☐ mepolizumab (Nucala) 300mg by subcutaneous route (administer as three separate 100mg injections at a distance of 5cm or more apart) every 4 weeks for _____ total doses.

IF HYPERSENSITIVITY OR ANAPHYLACTIC REACTION OCCURS

☒ Notify provider or Hospitalist on duty if afterhours, administer oxygen prn, administer diphenhydramine 25 mg IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

OUTPATIENT NURSE- PLACE STICKER HERE

Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: _____ **Date _____**

Printed name: _____ **Phone: _____** **Fax: _____**

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date _____**

Printed name: _____

OUTPATIENT NURSE- PLACE STICKER HERE