ADULT AMBULATORY INFUSION ORDER
Mepolizumab (NUCALA)

Weight: _________ kg   Height: _________ cm
Allergies: __________________________________________________________
Diagnosis Code: ___________________________________________________
Treatment Start Date: ___________   Patient to follow up with provider on date: _________________

**This plan will expire after 365 days at which time a new order will need to be placed**

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.

MEDICATIONS:

Dose:
☐ mepolizumab (NUCALA), 100 mg, subcutaneous, ONCE

Interval:
☐ Every 4 weeks

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. famotidine (PEPCID), 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
5. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

NURSING ORDERS:
1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes
2. Observe patient for hypersensitivity reactions, including anaphylaxis, for 30 minutes after administration
By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in:  ☐ Oregon ☐ [ ] (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);

My physician license Number is # [ ] (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); 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/Time: ___________________________
Printed Name: ___________________________  Phone: ___________________________  Fax: ___________________________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

☐ Beaverton
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ NW Portland
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ Gresham
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ Tualatin
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuKnight.com/InfusionOrders