**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:**

mepolizumab (NUCALA) injection, subcutaneous, ONCE

**Asthma:**

- 100 mg

**Eosinophilic granulomatosis with polyangitis (treatment) Dose:**

- 300 mg (administer as THREE separate 100 mg injections at a distance 5 cm or more apart)

**Interval:**

- Every 4 weeks

**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.
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 (OHSU HC-PAT-133-GUD, HMC C-132). 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 x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
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: ___________

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

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

☐ Beaverton  ☐ NW Portland
OHSU Knight Cancer Institute  Legacy Good Samaritan campus
15700 SW Greystone Court  Medical Office Building 3, Suite 150
Beaverton, OR 97006  1130 NW 22nd Ave
Phone number: 971-262-9000  Portland, OR 97210
Fax number: 503-346-8058  Phone number: 971-262-9600

☐ Gresham  ☐ Tualatin
Legacy Mount Hood campus  Legacy Meridian Park campus
Medical Office Building 3, Suite 140  Medical Office Building 2, Suite 140
24988 SE Stark  19260 SW 65th Ave
Gresham, OR 97030  Tualatin, OR 97062
Phone number: 971-262-9500  Phone number: 971-262-9700
Fax number: 503-346-8058  Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders