| VANCOUVER CLINIC®<br>**ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER**<br>Attn: Infusion department<br><br>**Benralizumab (FASENRA®)**<br>**Mepolizumab (NUCALA®)** | **NAME:**<br>**DOB:**<br>**INSURANCE:**<br>**PROVIDER NAME:**<br>**CLINIC NAME and Phone number:** |
|---|---|

Weight:_____lb/kg Height:_____inch/cm

Diagnostic Code ICD-10:_____ Diagnosis:_____

□ Initial Consult □ Annual Renewal

Treatment Start Date: _____

****These orders will expire after 365 days; new orders are needed after the expiration date****

This form serves as a referral to infusion services and for medication ordering.

Patients will be seen by our internal infusion clinician for purposes of providing care.

**GUIDELINES FOR ORDERING**:

- Send FACE SHEET and H&P or most recent chart note.
- Vancouver clinic infusion service will initiate Adverse Reaction Algorithm per our service protocol.
- Pre-medication(s) based on protocol (if needed)
- If labs are not accessible through Epic, please fax a copy of request lab as well (see below). Otherwise, authorized Vancouver Clinic infusion clinician to order the lab.
- Patient must be able to ambulate independently (if patient needs assistance with restrooming, a personal caregiver or capable family member must accompany and remain with patient for the duration of the appointment).

**LABS:**

- **CBC with differential** within 30 days of infusion appointment
- Stool O&P (in high risk population)
- Strongyloides IgG (in high risk population)

**MEDICATIONS:**
**Benralizumab (FASENRA®)**

☐ Initiation and maintainace: 30 mg, subcutaneous, every 4 weeks for 3 doses, followed by 30 mg, subcutaneous, every 8 weeks, starting week 16

☐ Maintenance: 30 mg, subcutaneous, every 8 weeks, next day due:_____

*Please fax the completed form and pertinent information to Fax: 360-604-1776*

***Vancouver Clinic Outpatient Infusion Service*** *- 700 NE 87th Ave Suite 330, Vancouver, WA 98664*
*Phone: 360-541-3245*

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Attn: Infusion department

**Benralizumab (FASENRA®)**
**Mepolizumab (NUCALA®)**

**NAME:**
**DOB:**
**INSURANCE:**
**PROVIDER NAME:**
**CLINIC NAME and Phone number:**

**Mepolizumab (NUCALA®)**

Asthma:

☐ 100 mg subcutaneously every 4 weeks, next day due:_____

Eosinophilic granulomatosis with polyangitis (treatment) Dose:

☐ 300 mg subcutaneously every 4 weeks, next day due:_____

Hypereosinophilic syndrome

☐ 300 mg subcutaneously every 4 weeks, next day due:_____

**Provider's signature: _____**

**Provider's printed name: _____Date:_____**

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