BEAUMONT INFUSION CENTERS

OMALIZUMAB (XOLAIR) & MEPOLIZUMAB (NUCALA) PRESCRIPTION

Location: ☐ **Royal Oak FAX: 248- 551-3168** ☐ **Troy FAX: 248-964-2409** ☐ **Lenox FAX: 947-523-4061** ☐ **Wayne FAX: 734-467-2505**
☐ **Grosse Pointe FAX: 586-498-4497** ☐ **Farmington Hills FAX: 248-471-8217** ☐ **Dearborn FAX: 313-593-8551**

Patient Name:	**Date of Birth:**	**Medical Record #:**
Physician Name:	**Address:**	**Office #:**
Diagnosis:		**Diagnosis Code (ICD-10):**

PATIENT INFORMATION
Please attach these *required* documents to Prescription (if not in EPIC): ● Copy of Insurance Card ● Labs ● Supporting clinical documentation ● Patient Demographics ☐ **NKDA** ☐ **Drug Allergies: _____**
Height: _____ ft _____ in **Weight:** _____ kg / lbs **Date:**_____

MEDICATION	**DOSE**	**# Doses**
Omalizumab (Xolair)	_____ mg SQ every ☐ 2 weeks ☐ 4 weeks ☐ Other:_____ ☐ Observe patient for 2 hour observation time for first 3 injections and then 30 minute observation time 4th injection onward.	
Mepolizumab (Nucala)	_____ mg SQ every ☐ 4 weeks ☐ Other:_____	
• Adult Anaphylaxis Protocol • Notify physician if reaction occurs		

Physician Signature _____ Beeper #_____ Date_____ Time_____