

# Uplizna Infusion Order

(Inebilizumab-cdon)



InfusionForHealth.com  
Ph: 888-777-1945 | Fax: 805-852-2636

Date: \_\_\_\_\_ Treatment Location: \_\_\_\_\_

**\*Please fax a copy of the following patient information:**

- Demographics       Insurance Information       Current Medications  
 Current CBC & CMP       Hep B Results       TB Results  
 Recent Office Notes       (AQP4) Antibody Positive Labs

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs / kg      Height: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-10: \_\_\_\_\_

## PROVIDER INFORMATION

Printed Provider's Name: \_\_\_\_\_

**Signature:** \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Email: \_\_\_\_\_

## PRE-MEDICATIONS:

(30 minutes before infusion)

Solu-Medrol:                       IV       125mg

Diphenhydramine:       PO       IV       25mg       50mg

Acetaminophen:       PO                       500mg       650mg

## UPLIZNA (INEBILIZUMAB-CDON) DOSAGE:

Date of Last Treatment, If Continuation: \_\_\_\_\_

### UPLIZNA IV LOADING DOSAGE

- 300 mg in 250 mL 0.9% Sodium Chloride  
on day 1 and day 15

### UPLIZNA IV MAINTENANCE DOSAGE

- 300 mg in 250 mL 0.9% Sodium Chloride  
6 months after loading dose,  
then every 6 months

# PATIENT ENROLLMENT FORM

Once complete, submit by fax **1-833-329-8477**  
or email **UPLIZNAHBYS@horizontherapeutics.com**



Complete all required fields, including prescriber's signature and date, to initiate patient enrollment process.  
For support and/or assistance obtaining patient signature, call Horizon By Your Side at 1-833-842-8477.

(\*Indicates a required field)

## PATIENT INFORMATION

First name\* \_\_\_\_\_ Last name\* \_\_\_\_\_  
Sex\*:  Male  Female  
Date of birth\*: \_\_\_\_\_  
(MM/DD/YYYY)  
Primary language \_\_\_\_\_ Email address \_\_\_\_\_  
Consent to leave voice message at patient and/or alternative contact telephone?  Yes  No  
Primary Telephone\* \_\_\_\_\_  
 Home  Cell  
Consent to send text message?  Yes  No  
Address\* \_\_\_\_\_  
City\* \_\_\_\_\_ State\* \_\_\_\_\_ ZIP Code\* \_\_\_\_\_  
Alternative contact name \_\_\_\_\_ Alternative contact telephone \_\_\_\_\_

## DIAGNOSIS

(Required for benefits investigation)

Diagnosis\*:  G36.0 - Neuromyelitis optica [Devic] \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
(MM/DD/YYYY)  
Has the patient ever tested positive for AQP4 antibodies?\*:  Yes  No  
Check all previous NMOSD therapies:  
 Oral immunosuppressant(s) (Mycophenolate Mofetil, Methotrexate, Azathioprine)  Steroid  Rituximab  
 Tocilizumab  Satralizumab-mwge  Eculizumab  
 Other: \_\_\_\_\_

## INSURANCE INFORMATION

(Please include front and back copies of insurance card(s) with this form)

Primary insurance\* \_\_\_\_\_ Secondary insurance \_\_\_\_\_  
Policy #\* \_\_\_\_\_ Policy # \_\_\_\_\_  
Policyholder's first and last name\* \_\_\_\_\_ Policyholder's first and last name \_\_\_\_\_  
Insurance company telephone\* \_\_\_\_\_ Insurance company telephone \_\_\_\_\_  
Group #\* \_\_\_\_\_ Group # \_\_\_\_\_  
Policyholder's DOB\*: \_\_\_\_\_ Policyholder's DOB: \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

UNINSURED: Patient is uninsured to my knowledge.

## INFUSION FACILITY

Do you have a preferred infusion facility?  Yes  No If yes, please provide the preferred infusion facility information below. If no, Horizon By Your Side will provide options for your patient.

Facility name \_\_\_\_\_  
Facility address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_  
Facility NPI # \_\_\_\_\_ Facility tax ID # \_\_\_\_\_

## PRESCRIBER INFORMATION

First name\* \_\_\_\_\_ Last name\* \_\_\_\_\_  
Address\* \_\_\_\_\_  
City\* \_\_\_\_\_ State\* \_\_\_\_\_ ZIP Code\* \_\_\_\_\_  
NPI #\* \_\_\_\_\_ Tax ID #\* \_\_\_\_\_ State license #\* \_\_\_\_\_  
Clinic/hospital affiliation \_\_\_\_\_  
Office contact name \_\_\_\_\_  
Office contact telephone\* \_\_\_\_\_ Fax\* \_\_\_\_\_  
Email address \_\_\_\_\_  
Preferred communication:  Telephone  Email  
Prescriber specialty: \_\_\_\_\_

## PRESCRIPTION INFORMATION

(Required for specialty pharmacy)

Prescription Information: UPLIZNA® (inebilizumab-cdon) ICD-10 Code: G36.0  
NDC: 75987-150-03: One carton containing three 100 mg/10 mL vials  
Dose: 300 mg per IV infusion  
Initial Rx:  300 mg IV infusion over 90 minutes at Day 1 and 2 weeks later  
Maintenance Rx:  300 mg IV infusion over 90 minutes every 6 months Refill: \_\_\_\_ times  
 Patient is Medically Urgent  
Medically Urgent means a patient who (1) requires accelerated treatment with UPLIZNA, (2) is experiencing a medical crisis or is at risk of attack and permanent disability; and (3) is either:  
– Not on an NMOSD maintenance therapy OR  
– On an alternate maintenance therapy

Type of premedication	Route of administration	Examples (or equivalent)	Administration time prior to UPLIZNA infusion
Corticosteroid	Intravenous	Methylprednisolone 80 mg to 125 mg	30 minutes
Antihistamine	Oral	Diphenhydramine 25 mg to 50 mg	30-60 minutes
Antipyretic	Oral	Acetaminophen 500 mg to 650 mg	30-60 minutes

Administration instructions: Dilute 300 mg (30 mL) in 250 mL 0.9% Sodium Chloride Injection and administer diluted infusion over approximately 90 minutes at an increasing rate: 42 mL/hour for first 30 minutes, followed by 125 mL/hour for the next 30 minutes, then 333 mL/hour until completion.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc.  
Noncompliance with state-specific requirements could result in outreach to the prescriber.

## Prescriber Certification

(Please see certification language on page 2)

\_\_\_\_\_  
Prescriber signature/Dispense as written\* Substitutions allowed  
Date\*: \_\_\_\_\_  
(MM/DD/YYYY)  
Written or e-signature only; stamps not acceptable.  
The above signature grants permission to share records with the co-management team and infusion facility.  
 I certify that the above therapy is medically necessary for the treatment of neuromyelitis optica spectrum disorder (NMOSD).\*  
I authorize Horizon Therapeutics USA, Inc. and its affiliates and their respective employees or agents (collectively, "Horizon") to transmit the above prescription by any means allowed under applicable law to the appropriate specialty pharmacy for my patient.

## Prescriber Certification

Please read and provide signature in Prescriber Certification section on page 1

I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered UPLIZNA® (inebilizumab-cdon) injection, 300 mg, for intravenous infusion in accordance with the labeled use of the product. If the "Patient is Medically Urgent" box has been checked, I further certify that treatment of the patient with UPLIZNA is Medically Urgent, requiring accelerated therapy. I understand that Horizon Therapeutics USA, Inc. and its affiliates and their respective employees or agents (collectively, "Horizon") will use this information to administer the Horizon By Your Side program (the "Program"), which provides a wide array of patient-focused services, including providing logistical and non-medical treatment support for UPLIZNA, as prescribed, and educating about the insurance process. By my signature, I also certify that (1) my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share protected health information with Horizon for purposes of the Program and (2) I have obtained the patient's authorization to release such information as may be required for AllCare Plus Pharmacy (or another party acting on behalf of Horizon) to assess insurance coverage for UPLIZNA and assistance in initiating or continuing UPLIZNA as prescribed. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use UPLIZNA or any other Horizon product or service, for any other person; (b) my decision to prescribe UPLIZNA was based solely on my professional determination of medical necessity; and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Horizon makes no representation or guarantee concerning coverage or reimbursement for any item or service. On behalf of the patient, Horizon expects the prescriber to coordinate with Horizon By Your Side to provide, to the best of the prescriber's ability, in-network infusion services and work with Horizon By Your Side to effectively communicate both in-network and out-of-network choices and the corresponding financial obligations of the patient connected to each choice. Should the prescriber knowingly perform out-of-network services without the knowledge and consent of the patient, the prescriber cannot balance bill the patient for the out-of-network services.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

By filling out and signing this form, the enrollment process in Horizon By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Horizon By Your Side. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Horizon will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

## Patient Consent for Patient Information, Enrolling in Services, and Accessing Financial Support (referred to as "Patient Authorization")

Please read and provide signature in Patient Authorization section below

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address, and telephone number to Horizon Therapeutics USA, Inc. and its affiliates and their respective agents and representatives (collectively, "Horizon"), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, "Horizon By Your Side") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon By Your Side and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon By Your Side for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or other products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon By Your Side otherwise as required or permitted by law. Further, I appoint the Program, on my behalf, to proceed with Program services and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization.

I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the Program. I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon By Your Side, 1 Horizon Way, Deerfield, IL 60015, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration remaining on this treatment or (b) 10 years from the date signed above. A photocopy of this Authorization will be treated in the same manner as the original.

### Patient Authorization

X

**Patient signature**  
Please read above

**Printed full name**

**Date:** (MM/DD/YYYY)

**DOB:** (MM/DD/YYYY)

## INDICATION AND IMPORTANT SAFETY INFORMATION

### INDICATION

UPLIZNA (inebilizumab-cdon) is indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

### IMPORTANT SAFETY INFORMATION

UPLIZNA is contraindicated in patients with:

- A history of life-threatening infusion reaction to UPLIZNA
- Active hepatitis B infection
- Active or untreated latent tuberculosis

### WARNINGS AND PRECAUTIONS

**Infusion Reactions:** UPLIZNA can cause infusion reactions, which can include headache, nausea, somnolence, dyspnea, fever, myalgia, rash, or other symptoms. Infusion reactions were most common with the first infusion but were also observed during subsequent infusions. Administer pre-medication with a corticosteroid, an antihistamine, and an anti-pyretic.

**Infections:** The most common infections reported by UPLIZNA-treated patients in the randomized and open-label periods included urinary tract infection (20%), nasopharyngitis (13%), upper respiratory tract infection (8%), and influenza (7%). Delay UPLIZNA administration in patients with an active infection until the infection is resolved.

Increased immunosuppressive effects are possible if combining UPLIZNA with another immunosuppressive therapy.

The risk of Hepatitis B Virus (HBV) reactivation has been observed with other B-cell-depleting antibodies. Perform HBV screening in all patients before initiation of treatment with UPLIZNA. Do not administer to patients with active hepatitis.

Although no confirmed cases of Progressive Multifocal Leukoencephalopathy (PML) were identified in UPLIZNA clinical trials, JC virus infection resulting in PML has been observed in patients treated with other B-cell-depleting antibodies and other therapies that affect immune competence. At the first sign or symptom suggestive of PML, withhold UPLIZNA and perform an appropriate diagnostic evaluation.

Patients should be evaluated for tuberculosis risk factors and tested for latent infection prior to initiating UPLIZNA.

Vaccination with live-attenuated or live vaccines is not recommended during treatment and after discontinuation, until B-cell repletion.

**Reduction in Immunoglobulins:** There may be a progressive and prolonged hypogammaglobulinemia or decline in the levels of total and individual immunoglobulins such as immunoglobulins G and M (IgG and IgM) with continued UPLIZNA treatment. Monitor the level of immunoglobulins at the beginning, during, and after discontinuation of treatment with UPLIZNA until B-cell repletion especially in patients with opportunistic or recurrent infections.

**Fetal Risk:** May cause fetal harm based on animal data. Advise females of reproductive potential of the potential risk to a fetus and to use an effective method of contraception during treatment and for 6 months after stopping UPLIZNA.

**Adverse Reactions:** The most common adverse reactions (at least 10% of patients treated with UPLIZNA and greater than placebo) were urinary tract infection and arthralgia.

**For additional information on UPLIZNA, please see Full Prescribing Information at UPLIZNAhcp.com.**

