Uplizna

INFUSION FOR HEALTH

Treatment Location: ______

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, TB Results, IgG Levels, Hep B Results, Recent Labs (CBC, CMP), Anti-aquaporin-4 (AQP4) Antibody Positive Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ G36.0 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI

☑ TB Status & Date (list results & attach clinicals): ______

☑ Quantitative serum immunoglobulin (list results & attach clinicals): ______

☑ Hepatitis B Status & Date (list results & attach clinicals): ______

☑ Anti-aquaporin-4 Antibody Positive Labs

PRE-MEDICATION ORDERS

Administered 30-60 minutes before infusion

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 500mg / ☐ 650mg / ☐ 650mg PO

☐ Solu-Medrol ☐ 125mg IV

☐ Or Equivalent Corticosteroid: ______

☐ Other: ______

Dose: ______ Route: ______ Frequency: ______

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ______

☐ CMP ☐ at each dose ☐ every ______

☐ CRP ☐ at each dose ☐ every ______

☐ IgA/IgG levels ☐ at each dose ☐ every ______

☐ Other ______ ☐ every ______

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

☑ Uplizna Intravenous Infusion

Loading Dose: ☐ 300mg in 250mL 0.9% sodium chloride
Frequency: On day 1 and day 15
Route: IV

Maintenance Dose: ☐ 300mg in 250mL 0.9% sodium chloride
Frequency: 6 months from the first infusion, then every 6 months
Route: IV

☐ Monitor patient for 60 minutes after completion of IV

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ______
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) ______ Provider Signature ______ Date ______

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***