Uplizna
(Inebilizumab-cdon)

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Insurance Information, All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, Most Recent Office Visit Note, Recent Labs

PATIENT INFORMATION

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

Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ G36.0 ☐ D89.84 ☐ G70.00 ☐ G70.01 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

The following lab results must be sent prior to initiation:

☑ TB
☑ Hepatitis B (HBsAg and HBcAb)
☑ Serum Immunoglobulins
☑ Anti-aquaporin-4 (AQP4) antibodies (NMOSD only)
☑ Anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibodies (MG only)

PRE-MEDICATION ORDERS

It is recommended to pre-medicate with Methylprednisolone or an equivalent corticosteroid, an antihistamine (e.g., Diphenhydramine), and an antipyretic (e.g., acetaminophen) approximately 30-60 minutes prior to each infusion

☐ Methylprednisolone ☐ 80mg / ☐ 125mg IV
☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO ☐ IV
☐ Acetaminophen ☐ 500mg / ☐ 650mg PO
☐ Other:_____

Dose: _____ Route: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Ig panel ☐ 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
☐ **Initial Dose:** 300mg on Day 1 and 300mg on Day 15
☐ **Maintenance Dose:** 300mg every 6 months (starting 6 months from the first infusion)

☐ 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.***