Uplizna Order Form
(inebilizumab-cdon)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

☐ G36.0 Neuromyelitis optica

Other: _____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Include Negative Hepatitis B, negative TB screening, quantitative serum immunoglobulins, and positive antiaquaporin-4 (AQP4).**

PRESCRIPTION

Pre-Medications

Acetaminophen: 650 mg PO

☐ Diphenhydramine: 25 mg PO **OR**

☐ Diphenhydramine: 25 mg IVP

Methylprednisolone: 125 mg SIVP

☐ Other: _____

Uplizna (inebilizumab-cdon)

Infuse in 250 mL of 0.9% Sodium Chloride over 90 minutes via pump.

Loading Dose:

☐ **IV:** Infuse 300 mg at weeks 0 and 2

Maintenance Dose:

☐ **IV:** Infuse 300 mg every 6 months*

maintenance dose scheduled 6 months from week 0 dose

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse protocol.

Post Treatment Observations: The patient is observed for 60 minutes following each infusion.

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____