

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
Primary Language: _____ Allergies: _____
Patient Preferred Location: _____

Diagnosis

ICD 10 Code

G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD) G70.01 Generalized Myasthenia Gravis (gMG) with Acute Exacerbation
G89.84 IgG4-Related Disease G70.00 Generalized Myasthenia Gravis without Acute Exacerbation

Other: _____

Patient Status:

New to Therapy
Continuing Therapy (Date of Last Dose _____)

Infusion Orders

Pre-Medications

Required:

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 week 0 and week 2

Maintenance Dose

IV: Infuse 300 mg every 6 months*

*Maintenance dose scheduled 6 months from week 0 dose

Is the patient on any other disease modifying therapy? Yes No
If yes, please note therapy and last dose: _____

Post Treatment Observation: The patient is observed for 60 minutes following each administration.

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

Comments: _____

Required Clinical Documentation

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 aquaporin-4 (AQP4).

Referring Patient Information

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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