

INFUSION ORDERS - Uplizna (inebilizumab-cdon)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:
REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change
<input type="checkbox"/> Order Renewal	
INFUSION OFFICE PREFERENCES (Optional)	
Preferred Location*:	

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Neuromyelitis optica spectrum disorder	ICD 10 Code: G36.0
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance info <input type="checkbox"/> Clinical/Progress notes supporting primary dx <input type="checkbox"/> Confirmation of negative pregnancy test/NA	<input type="checkbox"/> Confirmation of anti-aquaporin-4 (AQP4) antibody positive <input type="checkbox"/> Hep B Surface antigen and total core neg – results must be on file before infusion <input type="checkbox"/> Confirmed negative TB testing <input type="checkbox"/> Immune globulin levels WNL or plan for treatment if low

List Tried & Failed Therapies, including duration of treatment:

1) _____ 2) _____

MEDICATION ORDERS			
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Premedication			
Methylprednisolone	125mg	IVP	Administer 30 minutes prior to Uplizna
Acetaminophen	650mg	PO	Administer 60 minutes prior to Uplizna
Diphenhydramine	25mg	<input type="checkbox"/> PO <input type="checkbox"/> IVP	Administer 60 minutes prior to Uplizna

Biologic Infusion Order (Provider mark all that are needed below with dates outlined)			
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Medication	Dosing/Diluent	Route	Rate of infusion
<input type="checkbox"/> Uplizna 1 st dose	300mg in 250ml NS	IVPB	Titrate rate: ** 42ml/hr x 30min 125ml/hr x 30 min 333ml/hr for remainder of dose
<input type="checkbox"/> Uplizna 2 weeks after first dose	300mg in 250ml NS	IVPB	
<input type="checkbox"/> Uplizna Maintenance starting 6 months from first dose and every 6 mo	300mg in 250ml NS	IVPB	

OTHER ORDERS

**Observe Patient for 1 hour post infusion completion

First Dose: _____ ; 2nd Dose: _____ ; 6month later dose: _____

Hold treatment if the patient has any infections prior to infusion

Administer by IV infusion via an infusion pump and using a low-protein binding 0.2 or 0.22 micron in-line filter

PHYSICIAN INFORMATION

Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:	Date:	