MIC | METRO INFUSION CENTER

INFUSION ORDERS - Uplizna (inebilizumab-cdon)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ 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	
☐ Neuromyelitis optica spectrum disorder	ICD 10 Code: G36.0
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx ☐ Confirmation of negative pregnancy test/NA	☐ Confirmation of anti-aquaporin-4 (AQP4) antibody positive ☐ Hep B Surface antigen and total core neg – results must be on file before infusion ☐ Confirmed negative TB testing ☐ Immune globulin levels WNL or plan for treatment if low
List Tried & Failed Therapies, including duration of treatment: 1)	2)

MEDICATION ORDERS

Premedication			
Methylprednisolone	125mg	IVP	Administer 30 minutes prior to Uplizna
Acetaminophen	650mg	PO	Administer 60 minutes prior to Uplizna
Diphenhydramine	25mg	☐ PO ☐ IVP	Administer 60 minutes prior to Uplizna

Biologic Infusion Order (Provider mark all that are needed below with dates outlined)

Medication	Dosing/Diluent	Route	Rate of infusion
☐ Uplizna 1st dose	300mg in 250ml NS	IVPB	Titrate rate: ** 42ml/hr x 30min 125ml/hr x 30 min 333ml/hr for remainder of dose
☐ Uplizna 2 weeks after first dose	300mg in 250ml NS	IVPB	
☐ 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:

Fax referral to (866) 507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this form is strictly confidential and will become part of the patient's medical record.