Uplizna

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

Labs (Quantitative Serum Immunoglobulin Levels, TB, Hep B, and AQP4 Antibody)

Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

D89.84 IgG4-related disease G36.0 Neuromyelitis Optica Spectrum Disorder Other: ______________________________________

PRE-MEDICATION ORDER

Acetaminophen (Tylenol)	500mg	650mg	1000mg PO		(30-60 min pre-infusion)
Diphenhydramine (Benadryl)	25mg	50mg	PO	IV	(30-60 min pre-infusion)
Methylprednisolone (Solu-Medrol)	40mg IV	125mg IV			(30 min pre-infusion)

MEDICATION ORDER

Uplizna (inebilizumab-cdon) **Dose:** 300mg IV **Frequency:** Initial dosing: day 0 and day 15 then every 6 months (starting from first infusion)

every 6 months

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

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Provider Name **Provider Signature** **Date** **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

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