

UPLIZNA® (INEBILIZUMAB-CDON) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
----------------------	-----------------------	----------------

Address:

Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
---------------	----------------	---	----------------	--

Clinical Information

Primary Diagnosis Description: <input type="checkbox"/> Neuromyelitis Optica Spectrum Disorder (NMOSD) <input type="checkbox"/> IgG4-Related Disease <input type="checkbox"/> Generalized Myasthenia Gravis (gMG) with acute exacerbation <input type="checkbox"/> Generalized Myasthenia Gravis without acute exacerbation	ICD-10 Code: G36.0 D89.84 G70.01 G70.00
---	---

Allergies: <input type="checkbox"/> NKDA OR (List):
--

Is this the first dose?	<input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of last dose:	Hepatitis B Status:	Titer Date: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
--------------------------------	--	----------------------------	---

TB Status:	<input type="checkbox"/> PPD (negative) – date: <input type="checkbox"/> Last chest x-ray – date: <input type="checkbox"/> Past positive TB infection, course taken:	<input type="checkbox"/> Active TB <input type="checkbox"/> Unknown <input type="checkbox"/> QuantiFERON®TB Gold (negative) - Date _____
-------------------	--	--

Uplizna Prescription

Uplizna® (Inebilizumab-cdon) Refill as directed x1 year
Option Care Health to initiate services beginning with dose number _____ as indicated below:
 Dose 1: Infuse 300mg IV via infusion pump. Administer diluted infusion over approx. 90 minutes at an increasing rate. Start by infusing 42ml/hr for the first 30 min, followed by a rate of 125ml/hr for the next 30 min. Increase to 333ml/hr until complete.
 Dose 2: (2 weeks after dose 1) Infuse 300mg IV via infusion pump over 90 minutes at above increasing rate.
 Subsequent doses: (every 6 months starting 6 months from the first infusion). Infuse 300mg IV via infusion pump over 90 min at the above increasing rate.
Use a 0.2 or 0.22 micron in-line filter.
Withdraw 10ml from each of three 100mg/10ml vials (total 30ml) and add contents to 250ml of 0.9% sodium chloride ONLY.
Prior to every infusion, assess for active infection and delay infusion as appropriate.

Ancillary Orders

Anaphylaxis Kit
If this is a 1st infusion, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
 Yes No

Dosage:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (>30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Pre-Medication Orders

Methylprednisolone sodium succinate _____ mg IV given 30 min prior to infusion.
 Diphenhydramine _____ mg PO 30-60 min prior to infusion. Patient may decline.
 Acetaminophen _____ mg PO 30-60 min before infusion. Patient may decline.
 Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

No labs ordered at this time.
 Quantitative serum IG levels. Specify date and/or frequency: _____
 Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature:	Date:
------------------------------	--------------

Prescriber Information

Prescriber Name:	Phone:	Fax:
-------------------------	---------------	-------------

Address:	NPI:
-----------------	-------------

City, State:	Zip:	Office Contact:
---------------------	-------------	------------------------

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.