Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

UPLIZNA® (INEBILIZUMAB-CDON) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: ☐ **Neuromyelitis Optica Spectrum Disorder (NMOSD)**	**ICD-10 Code: G36.0**
☐ **IgG4-Related Disease**	**ICD-10 Code: D89.84**
☐ **Generalized Myasthenia Gravis (gMG) with acute exacerbation**	**ICD-10 Code: G70.01**
☐ **Generalized Myasthenia Gravis without acute exacerbation**	**ICD-10 Code: G70.00**

Allergies: ☐ NKDA OR (List):

Is this the first dose?	☐ Yes – date of first dose:	**Hepatitis B Status:**	Titer Date:
	☐ No – date of last dose:		☐ Positive ☐ Negative

TB Status:	☐ PPD (negative) – date:	☐ Active TB
	☐ Last chest x-ray – date:	☐ Unknown
	☐ Past positive TB infection, course taken:	☐ 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:**

