

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				ICD-10 Code: G36.0 ICD-10 Code: D89.84	
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: <input type="checkbox"/> Dose 1: Infuse 300mg. Administer diluted infusion over approx. 90 minutes at an increasing rate. Use a 0.2 or 0.22 micron in-line filter. 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. <input type="checkbox"/> Dose 2: (2 weeks after dose 1) Infuse 300mg over 90 minutes at above increasing rate. <input type="checkbox"/> Subsequent doses: (every 6 months starting 6 months from the first infusion). Infuse 300mg over 90 min at the increasing rate. 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 1 st infusion, would you like Option Care Health to provide an anaphylaxis kit with the 1 st dose? <input type="checkbox"/> Yes <input type="checkbox"/> No Dosage: <ul style="list-style-type: none"> • 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 <input type="checkbox"/> Methylprednisolone sodium succinate _____ mg IV given 30 min prior to infusion. <input type="checkbox"/> Diphenhydramine _____ mg PO 30-60 min prior to infusion. Patient may decline. <input type="checkbox"/> Acetaminophen _____ mg PO 30-60 min before infusion. Patient may decline. <input type="checkbox"/> Other: _____					
IV Flush Orders <input type="checkbox"/> <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. <input type="checkbox"/> <u>Implanted Port:</u> 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 <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> Quantitative serum IG levels. Specify date and/or frequency: _____ <input type="checkbox"/> 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>					
Prescriber Signature:				Date:	
Prescriber Information					
Prescriber Name:			Phone:		Fax:
Address:			NPI:		
City, State:		Zip:		Office Contact:	
Fax completed form, insurance information, and clinical documentation to: 866-248-4918					
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