EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Uplizna Order Form
(inebilizumab-cdon)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

☐ G36.0 Neuromyelitis optica

Other: _____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Include Negative Hepatitis B, negative TB screening, quantitative serum immunoglobulins, and positive antiaquaporin-4 (AQP4).**

PRESCRIPTION

Pre-Medications

Required:

Acetaminophen: 650 mg PO

☐ Diphenhydramine: 25 mg PO **OR**
☐ Diphenhydramine: 25 mg IVP
☐ Methylprednisolone: 125 mg SIVP
Other: _____

UPLIZNA (inebilizumab-cdon)

Infuse in 250 mL of 0.9% Sodium Chloride over 90 minutes via pump

Loading Dose

☐ **IV:** Infuse 300 mg at week 0 and week 2

Maintenance Dose

☐ **IV:** Infuse 300 mg every 6 months*
***Maintenance dose scheduled 6 months from week 0 dose**

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Post Treatment Observation: The patient is observed for 60 minutes following each administration.

Adverse Reactions: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____