UPLIZNA
(inebilizumab)

FAX to + 1 208.963.3245 or Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Negative Hep B, Serology
- Immunoglobulins Panel

PRIMARY DIAGNOSIS

☐ G36.0 Neuromyelitis optica
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: Give acetaminophen 500mg PO, diphenhydramine 25mg PO, and methylprednisolone 80mg IV 30 min prior to infusion
☐ Provider Prescribed: _____

_____

PRIMARY MEDICATION ORDER

☐ Uplizna 300mg IV on day 1 & day 15, then 300mg IV every 6 months (starting 6 months from 1st infusion)
☐ Uplizna 300mg IV every 6 months
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialists.for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____