Provider Order Form

UPLIZNA® (INEBILIZUMAB-CDON)

Uptiv Health

PATIENT

Full Name: ______________________ DOB: ______________________

Mobile Phone: ______________________ Weight: ________ ☐ lbs ☐ kg

Allergies: ______________________ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: ____________ Next Treatment Date: ____________

DIAGNOSIS ICD-10 code (must be specified)

☐ Neuromyelitis Optica Spectrum Disorder G36.0____________ ☐ Other: ______________________

PROVIDER

Provider Name: ______________________ Provider NPI: ______________________

Practice Name: ______________________ Referral Coordinator Name: ______________________

Practice Address: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO	☐ 500 mg	☐ 650 mg	☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV	☐ 25 mg	☐ 50 mg	
☐ Methylprednisolone (Solu-Medrol) IV	☐ 40 mg	☐ 125 mg	
☐ Cetrizine (Zyrtec) 10 mg PO			
☐ Other:			

THERAPY ADMINISTRATION

Medication	**Dose**	**Frequency**
☒ UPLIZNA® (inebilizumab-cdon), IV	☒ 300 mg	☐ Initial: Weeks 0 and 2, then every 6 months (starting 6 months from first infusion) ☐ Maintenance Dosing (check only if patient is currently on therapy): 300 mg IV infusion every 6 months

☒ Infuse over 90 minutes
☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every __________
☐ CMP	☐ at each dose	☐ every __________
☐ CRP	☐ at each dose	☐ every __________
☐ Other __________	☐ at each dose	☐ every __________

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ TB results ☐ AQP4 ☐ Serum Immunoglobulin ☐ Hepatitis B virus results

______________________ ______________________
Provider Signature Date