MRN:_____

DOB: _____

Plan of Treatment for Uplizna™ (Inebilizumab-cdon)

NOTE: *We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.*

1. Patient Name: _____Height (inches): _____Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: □ Primary ICD-10 Code: G36.0 Diagnosis description: Neuromyelitis optica

□ Secondary ICD-10 Code: _____Diagnosis description: _____

4. Pre-medications: ☐ None *OR* *Administered 30 minutes prior to infusion as selected:*

Acetaminophen: □ 1000 mg PO □ 650 mg PO □ 500 mg PO □ 325 mg PO	Diphenhydramine: □ 25 mg PO, □ 50 mg PO, □ 25 mg IVP, □ 50 mg IVP or Fexofenadine □ 60mg or □ 180 mg, □ Cetirizine 10 mg, □ Loratadine 10 mg Methylprednisolone □ 80 mg IVP □ 125 mg IVP or other _____mg IVP Famotidine: □ 20 mg PO, □ 40 mg PO, □ 20 mg IVP, □ 40 mg IVP

Pre-medicate with other: _____

5. Orders:

Uplizna™ 300 mg IV to infuse per protocol via pump.

6. Frequency:

□ **Induction dose**: Uplizna 300 mg IV to be infused over 90 minutes at 0 week and 2 weeks.

□ **Maintenance dosing**: Uplizna 300 mg IV every 6 months (24 weeks)

*Maintenance dosing is scheduled 6 months from initial 0 week dosing.

Post infusion monitoring as per protocol or as suggested in product information of 1 hour

Special orders: _____

_____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

8. Physician's Signature: _____/ _____Date: _____

(Dispense as written) (Substitution permitted)

No Stamp Signatures

Printed Physician's Name with Credentials: _____NPI: _____

MRN:_____

DOB: _____

Plan of Treatment for Uplizna™ (Inebilizumab-cdon)
Guidelines for Prescribing

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include anti-aquaporin-4 (AQP4) antibody positive lab results and/or tests to support diagnosis.**

☐ **Include Pre-Screening Requirements:**

___ Hepatitis B Surface Antigen
___ Tuberculosis Screening
___ Quantitative Serum Immunoglobulins

☐ Other as requested: _____

_____

_____

_____

_____

_____

_____

_____

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.