

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Uplizna™ (inebilizumab-cdon) Standard Plan of Treatment

### PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

G36.0 - Neuromyelitis Optica
- Other: _____

### REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	<b>REQUIRED:</b> Hepatitis B panel for new start patients	THERAPY:	
6	TB screening		<b>Continue current order until insurance approved</b>

### MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive inebilizuman-cdon if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new onset or deterioration neurological changes, and/or surgery.

#### PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

FDA labeling suggests premedication with antihistamine, antipyretic and IV corticosteroid

<b>IV</b>	Diphenhydramine	25mg	50mg	<b>PO</b>	Acetaminophen	325mg	500mg	650mg	1000mg	
	Methylprednisolone	40mg	125mg		Other:	Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

### MEDICATION/DOSE:

Uplizna™ 300 mg IV to infuse over approximately 90 minutes per step protocol  
**Monitor patient for 1 hour post infusion completion.**

### FREQUENCY:

Induction: Uplizna™ 300 mg IV at week 0 and week 2  
 Maintenance: Uplizna™ 300 mg IV every 6 months (24 weeks) starting 6 months from week 0 dose  
 Other: \_\_\_\_\_

### SPECIAL/LAB ORDERS:

\_\_\_\_\_  
 \_\_\_\_\_

**Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.**

Refills x 12 months unless noted otherwise here:

### LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.
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### PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

### PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

_____	_____
Dispense as written/Brand medically necessary	Substitution permitted