Local Infusion

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UPLIZNA (INEBILIZUMAB-CDON) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Mobile Number: _____ Patient Weight: _____kg
Allergies: _____
❑ Patient has known difficult venous access. Comments:_____
❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive, ICD 10: G36.0
□ Immunoglobulin G4-related disease (IgG4-RD) in adult patients, ICD 10: D89.84
□ Generalized myasthenia gravis (gMG) in adult patients who are antiacetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive, ICD 10: G70._____
❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____
Signature: _____ Date: _____
Contact Name: _____ Phone: _____ Fax: _____
Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ Methylprednisolone (Solu-Medrol) 125mg IVP
☑ Benadryl 25mg PO
☑ Acetaminophen (Tylenol) 500mg PO
❑ Famotidine 20mg IV
❑ Cetirizine (Zyrtec) 10mg PO
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Uplizna	300 mg	IV	❑ Initial: Weeks 0 and 2, then every 6 months (starting 6 months from first infusion) ❑ Subsequent: Every 6 months

LABS / SPECIAL INSTRUCTIONS