MIC | METRO INFUSION CENTER

INFUSION ORDERS - Uplizna (inebilizumab-cdon)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE

☐ Neuromyelitis optica spectrum disorder	ICD 10 Code: G36.0
☐ Other: ____	ICD 10 Code: _____________________

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Confirmation of anti-aquaporin-4 (AQP4) antibody positive
☐ Patient demographics AND insurance info	☐ Hep B Surface antigen and total core neg – results must be on file before infusion
☐ Clinical/Progress notes supporting primary dx	☐ Confirmed negative TB testing
☐ Confirmation of negative pregnancy test/NA	☐ Immune globulin levels WNL or plan for treatment if low

List Tried & Failed Therapies, including duration of treatment:

1) 2)

MEDICATION ORDERS

Premedication

Methylprednisolone	125mg	IVP	Administer 30 minutes prior to Uplizna
Acetaminophen	650mg	PO	Administer 60 minutes prior to Uplizna
Diphenhydramine	25mg	☐ PO ☐ IVP	Administer 60 minutes prior to Uplizna

Biologic Infusion Order (Provider mark all that are needed below with dates outlined)

Medication	Dosing/Diluent	Route	Rate of infusion
☐ Uplizna 1st dose	300mg in 250ml NS	IVPB	Titrate rate: ** 42ml/hr x 30min 125ml/hr x 30 min 333ml/hr for remainder of dose
☐ Uplizna 2 weeks after first dose	300mg in 250ml NS	IVPB	
☐ Uplizna Maintenance starting 6 months from first dose and every 6 mo	300mg in 250ml NS	IVPB	

OTHER ORDERS

**Observe Patient for 1 hour post infusion completion

First Dose: ______________________; 2nd Dose: ___________________; 6month later dose: _______________________

Hold treatment if the patient has any infections prior to infusion

Administer by IV infusion via an infusion pump and using a low-protein binding 0.2 or 0.22 micron in-line filter

PHYSICIAN INFORMATION

Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164