Patient Name:______________________________________

DOB:_____________________ Wt(kg):________________

Allergies:___________________ Phone:________________

# UPLINZA (inebilizumab)
# Infusion Orders

**Required Information:**

Signed order from prescribing provider

Patient demographics including insurance information

Supporting clinical documentation: Visit notes, other meds tried

Hep B & TB screening, AQP4 positive antibody result, Serum immunoglobulins

**Primary Diagnosis:**

Neuromyelitis Optica Spectrum disorder( ICD-10 :____________)

Other:_______________(ICD-10:_____________)

## UPLINZA ORDERS

Induction Dose: 300mg IV followed by 300mg IV 2 weeks later, then 300mg IV every 6 months

Maintenance Doses: Uplinza 300mg every 6 months

Date of Last Uplinza:_________

*Administered per manufacturer guidelines over 90 minutes*

## PRE-MEDICATIONS

PO Tylenol _____mg

PO Cetirizine _____mg

IV Solu-medrol _____mg

PO Loratadine _____mg

PO IV Diphenhydramine _____mg

PO IV Other:______________ _____mg

## LABS

| | | |
|---|---|---|
| CBC | ESR | Uric Acid |
| CMP | TB Quantiferon Gold | Other:______ |
| CRP | Hep B Core/Surface AG | Other:______ |

Frequency: Every Visit

Every Other Visit

One time only

Other:_____________

CPL Acct #:__________

## ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

| **Physician Name:** | **Phone:** | **Fax:** |
|---|---|---|
| **Physician Signature:** | **NPI:** | **Date:** |