Uplizna (inebilizumab-cdon)

Provider Order Form rev. 5/20/2022

AleraCare
A Healthcare Solutions Company
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PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ G36.0 Neuromyelitis optica spectrum disorder

☐ Other: _____

MEDICATION ORDER

Uplizna (inebilizumab-cdon)

Dose: ☐ 300mg IV

Frequency:

☐ Initial dosing: day 0 and day 15 then every 6 months (starting from first infusion)

☐ every 6 months

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

PRE-MEDICATION ORDERS (Required)

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO
(30-60 min pre-infusion)

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
(30-60 min pre-infusion)

☐ methylprednisolone (Solu-Medrol) ☐ 80mgIV ☐ 125mg IV
(30 min pre-infusion)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**