aleracare
advanced infusion centers™

FAX 833.329.4738

Uplizna (inebilizumab-cdon)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

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

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

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

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (Quantitative Serum Immunoglobulin Levels, TB, Hep B, and AQP4 Antibody)

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

Pre-Medication Order (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) ◯ 40mg IV ◯ 125mg IV (30 min pre-infusion)

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯