

Patient Information

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Is the patient pregnant, planning a pregnancy or nursing:		Last infusion date (if applicable): _____	
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 1 and day 15 then every 6 months (starting from first infusion). Qty: 2 doses every 6 months. Qty: 1 dose
------------------------------------	-----------------------	-------------------	--

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)

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

Do NOT administer heparin to this patient

Additional orders: _____

Adverse Reaction and Anaphylaxis Orders

Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x1; Benadryl 50 mg IV PRN for mild-moderate reactions x1)

Additional orders: _____

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

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

o 818.390.9696 aleraicare.com

Provider Signature
Date

Check here if this is a stat order