aleracare
advanced home infusion

HOME INFUSION ONLY

FAX 818.390.9697

Uplizna (inebilizumab-cdon)

Provider Order Form rev. 12/23/2024

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 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 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 **Provider Signature** **Date**

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

Check here if this is a stat order ◯