UPLIZNA® (INEBILIZUMAB-CDON) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Neuromyelitis Optica Spectrum Disorder (NMOSD)	**ICD-10 Code: G36.0**

Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of next dose due:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

TB Status:	☐ PPD (negative) – date:	☐ Active TB
	☐ Last chest x-ray – date:	☐ Unknown
	☐ Past positive TB infection, course taken:	☐ QuantiFERON®TB Gold (negative) - date _____

Uplizna Prescription

Uplizna® (Inebilizumab-cdon) Refill as directed x1 year

Option Care Health to initiate services beginning with dose number _____ as indicated below:

☐ Dose 1: Infuse 300mg. Administer diluted infusion over approx. 90 minutes at an increasing rate. Use a 0.2 or 0.22 micron in-line filter. Start by infusing 42ml/hr for the first 30 min, followed by a rate of 125ml/hr for the next 30 min. Increase to 333ml/hr until completion.

☐ Dose 2: (2 weeks after dose 1) Infuse 300mg over 90 minutes at above increasing rate.

☐ Subsequent doses: (every 6 months starting 6 months from the first infusion). Infuse 300mg over 90 min at the increasing rate.

Withdraw 10ml from each of three 100mg/10ml vials (total 30ml) and add contents to 250ml of 0.9% sodium chloride ONLY.
Prior to every infusion, assess for active infection and delay infusion as appropriate.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Pre-Medication Orders

Pre-medicate with a corticosteroid, antihistamine, and antipyretic.

☐ Methylprednisolone _____ mg IV given 30 min prior to infusion.
☐ Diphenhydramine _____ mg PO 30-60 min prior to infusion. Patient may decline.
☐ Acetaminophen _____ mg PO 30-60 min before infusion. Patient may decline.
☐ Other: _____

IV Flush Orders

☐ Peripheral: NS 2 to 3 mL pre-/post-use.
☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.
☐ Quantitative serum IG levels. Specify date and/or frequency: _____
☐ Other:

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	

