immersiv HEALTH

UPLIZNA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ G36.0 Neuromyelitis optica

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

☐ Negative TB Screening

☐ Immunoglobulins Panel

☐ HBsAg, Anti-HBc & Anti-HBs

MEDICATION ORDER

☐ **LOADING:** Uplizna® (inebilizumab) 300mg IV in 250ml NS over 90 minutes at week 0 and week 2

☐ **MAINTENANCE:** Uplizna® (inebilizumab) 300mg IV in 250ml NS over 90 minutes every 6 months

* Maintenance dosing scheduled 6 MONTHS from initial Week 0 dosing

☐ **OTHER:** _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE:

_____

PRE-MEDICATIONS

REQUIRED

☑ Acetaminophen: 500 mg	☑ PO	☐ IV
☑ Methylprednisolone: 125 mg	☐ PO	☑ IV
☑ Diphenhydramine: 25 mg	☐ PO	☑ IV

OTHER: _____ ☐ PO ☐ IV

Patient to be observed for 60 minutes following each administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ | _____ **DATE:** _____

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN