

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

D89.84 IgG4-related disease
 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. Administer per protocol.
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: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS) SUBSTITUTION PERMITTED DISPENSE AS WRITTEN