

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 Hepatitis B

☐ 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: _____

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

PRE-MEDICATIONS
REQUIRED
☒ Acetaminophen: 500 mg ☒ PO ☐ IV

☒ Methylprednisolone: 125 mg ☐ PO ☒ IV

☒ Diphenhydramine: 25 mg ☐ PO ☒ IV

OTHER: _____ ☐ PO ☐ IV