LIFE SPECIALTY SOLUTIONS

UPLIZNA
(inebilizumab)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card
2. History & Physical
3. Patient Demographics
4. Most Recent Labs
5. Medication List
6. Tried/Failed Therapies
7. Negative TB Results
7. Negative Hep B, Serology
7. Immunoglobulins Panel

PRIMARY DIAGNOSIS

☐ G36.0 Neuromyelitis optica

☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: Give **Acetaminophen** 650mg PO, **Diphenhydramine** 25mg PO, and **Methylprednisolone** 80mg IV 30 min prior to infusion

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Uplizna 300mg IV on day 1 & day 15, then 300mg IV every 6 months (starting 6 months from 1st infusion)

☐ Uplizna 300mg IV every 6 months

☐ Other: _____

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE