

Uplizna (inebilizumab) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with completed order form: (for detailed information refer to Uplizna Ordering Guide below)

- Copy of insurance card ● Patient demographics ● History & physical
- Labs (HBV, TB, AQP4, quantitative serum immunoglobulins)

Patient Information

Male Female Height: _____ in/cm Weight: _____ lbs/kg NKDA Allergies: _____

Is this the 1st dose? Yes No, last infusion: _____ Next infusion due: _____ Line type: PIV PICC Port Other

3. Diagnosis and Clinical Information

Primary diagnosis (required): Neuromyelitis Optica (G36.0) IgG4-related diseases ICD-10: _____
 gMG (AChR+ / MuSK+) Other: _____

4. Prescription Information

Medication	Uplizna 100mg/10mL single dose vials (3 vials/carton)
Dosing / Frequency	<input type="checkbox"/> Initial loading dose: 300mg IV infusion on day 0 and on day 15 <input type="checkbox"/> Maintenance dose: 300mg IV infusion every 6 months (from first infusion) <input type="checkbox"/> Other _____
Administration	<input checked="" type="checkbox"/> Dilute per manufacturer guidelines prior to IV infusion using 0.2 or 0.22 micron in-line filter <input checked="" type="checkbox"/> Infuse via infusion pump 42mL/hr for the first 30 min, then 125mL/hr for the next 30 min, then 333mL/hr as tolerated to completion
Quantity / Refills	Dispense 1 month supply; Refill x 12 months <input type="checkbox"/> Other: _____ Dispense all medical supplies necessary for infusion

5. Additional Orders

- RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per PromptCare Policy and Procedure
- Premedications:** Give 30 to 60 min prior to each infusion
 - Diphenhydramine** 25-50mg PO **Acetaminophen** 650mg PO **Methylprednisolone** 80mg (OR ____ mg) slow IV push
- RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.
- RN to monitor patient for at least 1 hour post infusion. Educate patient on possible side effects, reactions, and when to contact physician
- Other: _____

6. Adverse Reaction Orders

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License No.: _____ DEA NO.: _____ NPI: _____

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately

Uplizna (inebilizumab) Ordering Guide

- ❖ For new patients, please submit completed Uplizna Order Form with all available supporting documentation to facilitate the approval process
- ❖ **Please submit with Uplizna Order Form the following supporting documentation:** *
 - Progress notes with documentation of diagnosis
 - Labs and test results supporting primary diagnosis
 - TB screening (contraindicated in active or untreated latent tuberculosis)
 - Hepatitis B screening (contraindicated in active hepatitis B infection)
 - AQP4 seropositive lab result
 - Serum immunoglobulins
 - Medication history including prior and/or concurrent NMOSD therapies

**Specific plans may require additional documentation for prior authorization.*
- ❖ Additional information for consideration:
 - Uplizna may be administered in a patient's home or in an infusion suite, per individual insurance plan
 - Patients should be up to date on guideline recommended vaccination schedules at least 4 weeks prior to initiating Uplizna. Live or live-attenuated vaccinations are not recommended during treatment or after treatment discontinuation (until B-cell repletion)
 - Serum immunoglobulins are recommended to be assessed at the beginning of treatment, during treatment, and after discontinuation of Uplizna (until B-cell repletion)
 - Lab draws will need to be arranged at prescriber's office or a lab facility of patient's preference
- ❖ Resources:
 - Provider to enroll patient in Horizon By Your Side patient support program on the Uplizna website [[UPLIZNA-Patient-Enrollment-Form.pdf \(hzndocs.com\)](#)]. This is not required but highly recommended to provide patients with support throughout therapy, including manufacturer resources if needs arise
 - For expedited access to therapy, Uplizna Starter Bridge Program is available for eligible patients on manufacturer website [[UPLIZNA-Starter-Bridge-Program.pdf \(hzndocs.com\)](#)]