



Phone: 608-690-7210
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www.MySmartInfusion.com

UPLIZNA (INEBILIZUMAB-CDON)
Infusion Order Form

Location

- ☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

Patient Information

Patient Name: _____ DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

- ☐ Neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive, ICD 10: G36.0
☐ Immunoglobulin G4-related disease (IgG4-RD) in adult patients, ICD 10: D89.84
☐ Generalized myasthenia gravis (gMG) in adult patients who are antiacetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive, ICD 10: G70. _____

Required Tests

TB/QuantiferON Negative on _____

- ☐ May proceed with infusion with additional testing every _____ years
☐ No follow up testing necessary

Quantitative Serum Immunoglobulin (within 3 months & attach results)

Hepatitis B Status & Date: _____

Pregnancy test results if applicable _____

Pre-Medication Orders Required

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 125mg IV

Ondansetron (Zofran) ☐ 4mg ☐ PO ☐ IV

Other: _____ Route: _____

Dose: _____ Frequency: _____

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:

- ☒ Acetaminophen 650mg PO,
☒ Diphenhydramine 25mg-50mg PO or IV
☒ Ondansetron 4mg IV
☒ Sodium Chloride 0.9% 1000mL IV
☒ Methylprednisolone 125mg IV
☒ Albuterol Sulfate 2.5mg nebulized
☒ Oxygen 1-6LPM continuous flow
☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type

☒ Other: _____

(Uplizna) Medication Order

Refill x12 months unless otherwise noted: _____

Patient Weight: _____ KG

Dosage

☐ 300 mg IV

☐ Initial: Weeks 0 and 2, then every 6 months (starting 6 months from first infusion)

☐ Subsequent: Every 6 months

Required Documents

- ☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____