

UPLIZNA

(inebiumaab)

Central Intake Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Hepatitis B Results
- Negative TB Results
- Serum immunoglobulins results
- Medication List

PRIMARY DIAGNOSIS

- ☐ D89.84 - IgG4 -related disease
- ☐ G36.0 - Neuromyelitis optica
- ☐ Other: _____

CLINICAL MONITORING: **To be maintained and monitored by prescriber*

- ✓ Quantitative serum immunoglobulins to be maintained and monitored by prescriber

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

Recommended premeds are at least: methylprednisolone 80mg-125mg IV, Diphenhydramine 25-50mg PO, and Acetaminophen 500mg-650mg PO

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|---|--|--|---|
| ☐ Diphenhydramine 25mg PO | ☐ Pepcid 20mg PO | ☐ Cetirizine 10mg PO | ☐ Solu-medrol 40mg IVP |
| ☒ Diphenhydramine 50mg PO | ☐ Pepcid 20mg IVP | ☒ Tylenol 650mg PO | ☒ Solu-medrol 125mg IVP |
| ☐ Diphenhydramine 25mg IVP | ☐ Other: _____ | | |
| ☐ Diphenhydramine 50mg IVP | | | |

PRIMARY MEDICATION ORDER

- ☐ Uplizna 300mg IV at week 0 and week 2 then 300mg IV every six months
- ☐ Other: _____
- ☐ First Dose: ☐ Y ☐ N
- ☒ Refill x12 months unless otherwise noted:

LINE USE/CARE ORDERS

- ☒ Start PIV/ACCESS CVC ☒ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date

