Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare
MedFuse

Uplizna (Inebilizumab-cdon) Infusion Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Ceterizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Laboratory Order:

□ CBC □ at every dose □ every _____
□ CMP □ at every dose □ every _____
□ CRP □ at every dose □ every _____
□ Other:

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Hepatitis B status and date
□ Tuberculosis status and date
□ Quantitative serum immunoglobin labs
□ Other:

Patient height and weight:

Patient Height (cm):

Patient Weight (kg):

Uplizna Medication Order (Please select ONE):

□ Initial start w/ maintenance dosing:

- 300 mg IV initial dose
- 300 mg IV second dose 15 days after
- Subsequent to first 2 doses, 300mg IV dose every 6 months

□ Maintenance dosing every 6 months

- 300 mg every 6 months

Last Dose: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____