Checklist for Uplizna (inebilizumab-cdon) Referral

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____**NPI:** _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
    - Note should include any therapies tried/failed, and must include discussion about Uplizna
    - Medication list and allergies
    - Last Uplizna infusion note, if available
- ❑ Supporting lab reports/orders for Uplizna treatment
    - Baseline: AQP4 Antibody confirmation (NMOSD), CBC w diff, CMP, serum immunoglobulins, Hepatitis B screening, and TB screening
    - *For continued therapy:* CBC w diff and CMP prior to each infusion. Routine immunoglobulins.
    - Ensure all vaccinations are up to date prior to treatment. Live vaccines should be given at least 4 weeks prior to treatment, and non-live vaccines should be given at least 2 weeks prior to treatment.
- ❑ Uplizna Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible –

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

Infusion Center of New England
18 Washington Street, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Uplizna (inebilizumab-cdon)

Date of Order: _____

❑ New Start ❑ Maintenance
Date of last infusion: _____

Patient Name: _____ DOB: _____ M/F: ____

Diagnosis (include ICD-10 code/s):_____

❑ **NKDA** **Allergies: _____**

Patient Weight: _____

Premedication:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV in 50ml over 15min
❑ Other: _____

Lab Orders:

❑ CBC w/diff, CMP every _____ weeks
❑ Other: _____
_____

Uplizna Medication Order:

❑ **Uplizna 300mg/250ml IV on Day 1 and Day 15**
❑ **Uplizna 300mg/250ml IV once every 6 months**

✓ Post infusion observation for 1 hour
  ❑ NS 100ml/hr x 1 hour

Administration:

- ✓ Infuse at rate of 42ml/hr for 30min, increase to 125ml/hr for 30min, then 333ml/hr until completion
- ✓ Vital Signs: Pre-treatment, at every rate change, and post-treatment
- ✓ Do not administer if patient has signs or symptoms of active infection
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

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