INEBILIZUMAB-CDON ORDERS (Uplizna)

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Specifics of tried and failed therapies
☐ Documentation of contraceptive use (if applicable)
☐ TB/HepB Screening Results/CBC w/diff/CMP/Quantitative Immunoglobulins
☐ Completed and Signed Referral
Typical Payable Dx Codes: D89.84 Immunoglobulin G4 Related Disease G36.0 Neuromyelitis optica G70.00 Myasthenia gravis without (acute) exacerbation G70.01 Myasthenia gravis with (acute) exacerbation
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834

SPECIALTY INFUSION CENTER
An Access Infusion Care Company

INEBILIZUMAB-CDON ORDERS (Uplizna)

CENTERS AT SIC
An Access Infusion Care Managed Company

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change

First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other:

DIAGNOSIS

☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

Prior Therapies:

☐ Documentation of contraceptive use (if applicable)

☐ Hepatitis B Screening: ☐ Positive ☐ Negative-Date:	☐ TB Screening: ☐ Positive ☐ Negative-Date:

gMG ONLY MG-ADL score: MGFA clinical classification (I, II, III, IV, V):

gMG ONLY: Has the patient ever tested positive for AChR antibodies	☐ Yes	☐ No	Attach result if applicable
gMG ONLY Has the patient ever tested positive for MuSK antibodies?	☐ Yes	☐ No	Attach result if applicable
NMOSD ONLY Has the patient ever tested positive for AQP4 antibodies?	☐ Yes	☐ No	Attach result if applicable

PRESCRIBING INFORMATION

LAB ORDERS Frequency: Every

Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Vit D ☐ Vit B12 ☐ IgA, IgG, IgM ☐ Hepatitis Panel ☐ Lymphocyte subset panel

PREMEDICATIONS (administer 30-60 minutes prior to infusion-required per PI)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO	Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV
Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒ **Inebilizumab-cdon (Uplizna)**	100mg/10mL	☐ **Induction:** 300mg on Day 1 and Day 15, then ☐ **Maintenance:** 300mg every 6 months (begin 6 months after Day 1) Infuse in 250ml 0.9%NS IV over 90 minutes	☐ 6 vials, no refills ☐ 3 vials Refills:

If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 60 minutes after the infusion.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion: Use 50ml 0.9%NS to flush residual priming volume	PIV: Flush 3-10mL 0.9%NS before/after PICC/Midline/Port: Flush 10mL 0.9%NS before/after, then 3mL Heparin 10u/mL (PICC/Midline)/ 5mL Heparin 100u/mL (Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine 25-50mgPO or IVP(2-5min); Acetaminophen 325-650mgPO; Methylprednisolone 125mgIVP(≥5min); Epinephrine 0.3mgIM/SQ, may repeat×1; 0.9%NS 500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine 25mgPO or IVP(2-5min); Acetaminophen 325mgPO; Methylprednisolone 40mgIVP(≥5min); Epinephrine 0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS 500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only): 1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834