INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Uplizna *inebilizumab-cdon*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ 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. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)

☐ Negative TB

☐ Demographics

☐ Labs and tests supporting diagnosis

☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☑ Methylprednisolone (Solu-Medrol) 125 mg IVP

☑ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Uplizna	300 mg	IV	☐ Initial: weeks 0 and 2, then every 6 months (starting 6 months from first infusion) ☐ Subsequent: every 6 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____