

Inebilizumab-cdon (Uplizna)

Provider Order Form rev. 3/25/2022



PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- Provide nursing care per IVX Standard Nursing Procedures, including reaction management & post-infusion observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)
- Tuberculosis status and date (list results here & attach clinicals)

- Quantitative serum immunoglobulin (list results here & attach clinicals):

- Hepatitis B status & date (list results here & attach clinicals):

PRE-MEDICATION ORDERS (REQUIRED)

- acetaminophen (Tylenol) 650mg PO
- diphenhydramine 50mg PO
- methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS (OPTIONAL)

- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- famotidine (Pepcid) 20mg PO
- Other: _____
Dose: _____ Route: _____
Frequency: _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____

THERAPY ADMINISTRATION

- Inebilizumab-cdon (Uplizna) intravenous infusion
- Induction:
 - Dose: 300mg in 250ml 0.9% sodium chloride
 - Frequency: on Day 1 and Day 15
 - Rate: Start at 42ml/hr x30 min, 125ml/hr x 30 min, then 333ml/hr for remainder of infusion
 - Duration should be approximately 90 minutes
 - Administer through an intravenous line containing a sterile, low-protein binding 0.2 or 0.22 micron in-line filter.
 - After induction, continue with maintenance dosing below
- Maintenance:
 - Dose: 300mg in 250ml 0.9% sodium chloride
 - Frequency: every 6 months from the first infusion
 - Rate: Start at 42ml/hr x30 min, 125ml/hr x 30 min, then 333ml/hr for remainder of infusion
 - Duration should be approximately 90 minutes
 - Administer through an intravenous line containing a sterile, low-protein binding 0.2 or 0.22 micron in-line filter.
- Flush with 0.9% sodium chloride at the completion of infusion
- Patient required to stay for 60-min observation post infusion
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Hepatitis B virus, quantitative serum immunoglobulins, and tuberculosis screening is required before the first dose. | Prior to every infusion premedicate with a corticosteroid, an antihistamine, and an antipyretic. | Monitor patients closely during and for at least one hour after infusion.

Provider Name (Print)	Provider Signature	Date		
FAX NUMBERS				
<input type="checkbox"/> CHICAGO: 312-253-7244	<input type="checkbox"/> INDIANAPOLIS: 844-983-2028	<input type="checkbox"/> PHILADELPHIA: 844-820-9641	<input type="checkbox"/> WEST TN/AR: 888-615-1445	
<input type="checkbox"/> COLUMBUS: 844-627-2675	<input type="checkbox"/> JACKSONVILLE: 904-212-2338	<input type="checkbox"/> RALEIGH: 919-287-2551	<input type="checkbox"/> MIDDLE TN: 888-615-1445	
<input type="checkbox"/> BAY AREA: 844-889-0275	<input type="checkbox"/> DAYTONA: 386-259-6096	<input type="checkbox"/> KANSAS CITY: 844-900-1292	<input type="checkbox"/> SARASOTA: 941-870-6550	<input type="checkbox"/> EAST TN: 615-425-7427
<input type="checkbox"/> CHARLOTTE: 336-663-0143	<input type="checkbox"/> HARRISBURG: 844-859-4235	<input type="checkbox"/> ORLANDO: 844-946-0867	<input type="checkbox"/> SOUTHWEST FL: 813-283-9144	
<input type="checkbox"/> CINCINNATI: 844-946-0868	<input type="checkbox"/> HARTFORD: 860-955-1532	<input type="checkbox"/> PALM BEACH: 561-768-9044	<input type="checkbox"/> TAMPA: 844-946-0849	