

# Inebilizumab-cdon (Uplizna)



## Provider Order Form

rev. 11/23/2021

### PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
<b>Patient Status:</b> <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](http://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
-----------------------	--------------------	------

Email [ivxintake@ivxhealth.com](mailto:ivxintake@ivxhealth.com) or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> BAY AREA: 844-899-0275   | <input type="checkbox"/> COLUMBUS: 844-627-2675     | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445   |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARRISBURG: 844-859-4235   | <input type="checkbox"/> KANSAS CITY: 844-900-1292  | <input type="checkbox"/> TAMPA: 844-946-0849        | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
| <input type="checkbox"/> CHICAGO: 312-253-7244    | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> ORLANDO: 844-946-0867      | <input type="checkbox"/> SOUTHWEST FL: 844-946-0849 | <input type="checkbox"/> EAST TN: 888-615-1445   |