Inebilizumab-cdon (Uplizna)

IVX HEALTH

Provider Order Form *rev. 10/12/2022*

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

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 Nursing Procedures, including reaction management and post-procedure 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 & attach clinicals):
_____

☑ Quantitative serum immunoglobulin (list results & attach clinicals):
_____

☑ Hepatitis B status & date (list results & 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 infusion completion
☑ 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

☐ CONNECTICUT: 860-955-1532	☐ HARRISBURG: 844-859-4235	☐ PALM BEACH: 561-768-9044	☐ TAMPA: 844-946-0849
☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ PHILADELPHIA: 844-820-9641	☐ WEST TN/AR: 888-615-1445
☐ BAY AREA: 844-889-0275	☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ RALEIGH: 919-287-2551	☐ MIDDLE TN: 888-615-1445
☐ CHARLOTTE: 336-663-0143	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ SARASOTA: 941-870-6550	☐ EAST TN: 615-425-7427
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ ORLANDO: 844-946-0867	☐ SOUTHWEST FL: 813-283-9144	