Uplizna®

Provider Order Form Rev. 06/2024

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: _______ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Neuromyelitis optica [Devic], G36.0

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Uplizna® (Inebilizumab)	300 mg	☐ **INITIAL:** Infuse IV over 90 minutes at Weeks 0 and 2, then every 6 months x 1 year ☐ **MAINTENANCE:** Infuse IV over 90 minutes every 6 months x 1 year *Observe patient for 1 hour after completion of infusion.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: ______________________

Date of last treatment: ______________ Date of next treatment: ______________

PRE-MEDICATION ORDERS

- Acetaminophen 650mg PO 30-60 minutes prior to infusion
- Diphenhydramine 25mg/50mg PO 30-60 minutes prior to infusion
- Methylprednisolone 100mg IV 30-60 minutes prior to infusion

☐ Other: ______________________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q ________ ☐ CMP q ________ ☐ CRP q ________

☐ ESR q ________ ☐ LFTs q ________ ☐ Other: ________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________ NPI: __________ TIN: __________ Specialty: __________

Address: ______________________ City/ST/Zip: ______________________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient has been diagnosed with neuromyelitis optica spectrum disorder (NMOSD).

☐ The patient is anti-aquaporin-4 (AQPR) antibody positive. ***(Attach copy of labwork)***

☐ The patient exhibits at least **ONE** of the following core clinical characteristics of NMOSD: ***(Check all that apply)***

- ☐ Optic neuritis
- ☐ Acute myelitis
- ☐ Area postrema syndrome (unexplained hiccups or N/V)
- ☐ Acute brainstem syndrome
- ☐ Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
- ☐ Symptomatic cerebral syndrome with NMOSD-typical brain lesions
- ☐ Other: ______________________

☐ The patient has a history of relapses (acute attack from NMOSD) requiring rescue therapy.

- ☐ ONE or more relapses during the previous 12 months (prior to initiating Uplizna)
- ☐ TWO or more relapses during the previous 24 months (prior to initiating Uplizna)
- Specify dates of relapses (Month/Year): ______________________

☐ Diagnosis of multiple sclerosis or other diagnoses have been ruled out.

LAB AND TEST RESULTS (required)

- Hepatitis B Screening (submit results to start therapy)
- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by**:** ☐ Infusion Center ☐ Referring Physician

☐ Positive anti-aquaporin-4 (AQPR) antibodies

PRIOR FAILED THERAPIES

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________