Uplizna®

Provider Order Form Rev. 07/2025

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

☐ Immunoglobulin G4-Related Disease [IgG4-RD], D89.84

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Uplizna® (Inebilizumab)	300 mg	☐ **INITIAL:** Infuse IV over 90 minutes once every 2 weeks x 2 doses ☐ **MAINTENANCE:** Infuse IV over 90 minutes once 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:

For 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 (≥1 in previous 12 months or ≥2 in previous 24 months) requiring rescue therapy.

- Specify date(s) of relapse (Month/Year): _____

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

For IgG4-RD:

☐ The patient has elevated serum IgG Subclass 4 levels. ***(Attach copy of labwork)***

☐ The patient has documented IgG4-RD organ involvement. Specify affected organ(s): _____

☐ The patient has a history of recurrent IgG4-RD flares requiring steroid therapy.

- Number of flares within the last year: _____ ; Date(s) of previous flares (Month/Year): _____

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

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: _____