

**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  Myasthenia Gravis without (acute) exacerbation, G70.00  
 Immunoglobulin G4-Related Disease [IgG4-RD], D89.84  Myasthenia Gravis with (acute) exacerbation, G70.01

**INFUSION ORDERS**

MEDICATION	DOSE	DIRECTIONS/DURATION
Uplizna® (Inebilizumab)	300 mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV over 90 minutes once every 2 weeks x 2 doses <input type="checkbox"/> <b>MAINTENANCE:</b> 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 ( $\geq 1$  in previous 12 months or  $\geq 2$  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): \_\_\_\_\_

For Myasthenia Gravis:

- The patient is positive for anti-acetylcholine receptor (AChR) antibodies. **(Attach copy of labwork)**
- The patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease.
- The patient has a baseline MG-Activities of Daily Living (MD-ADL) score of  $\geq 5$ ; Score: \_\_\_\_\_

**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: \_\_\_\_\_