UPLIZNA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____ Secondary Insurance (If Applicable): _____

Plan #: _____ Plan #: _____

Group #: _____ Group #: _____

RX Card (PBM): _____ RX Card (PBM): _____

BIN: _____ PCN: _____ BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ G36.0 Neuromyelitis optica ☐ Other ICD-10/Diagnosis: _____

Hepatitis B vaccination: ☐ Yes ☐ No Date: ____-____-____ Hepatitis B screening: ☐ Positive ☐ Negative Date: ____-____-____

☐ HB core antibody HBcAb+ results: ☐ Positive ☐ Negative Date: ____-____-____

☐ Does the patient have active or latent TB infection? ☐ Yes ☐ No Tuberculosis screening: ☐ Positive ☐ Negative Date: ____-____-____

First two loading doses completed: ☐ Yes ☐ No Note: Uplizna loading doses must be administered in a controlled setting.

** Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

UPLIZNA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose	Directions	Refills
☐ Uplizna® (inebilizumab injection)	☐ 100mg/10mL SDV ☐ Other: _____	☐ Initial Dose: ☐ Infusion 1: 300mg in 250mL of 0.9% NS. ☐ Infusion 2: (2 weeks later): 300mg in 250mL of 0.9% NS. ☐ Other: _____ ☐ Maintenance Dose: ☐ Every 6 months (from first infusion) infuse 300mg in 250mL of 0.9% N ☐ Other: _____	_____

Pre-medication	Dose/Frequency		Refills
IV Corticosteroids	☐ 80mg IV Methylprednisolone ☐ 125mg IV Methylprednisolone ☐ Other: _____	☐ Prior to each infusion ☐ Other: _____	_____
Oral Antihistamines	☐ 60 mg fexofenadine ☐ 50 mg diphenhydramine ☐ Other: _____	☐ Prior to each infusion ☐ Other: _____	_____
Oral Antipyretic	☐ 500 mg acetaminophen ☐ Other: _____	☐ Prior to each infusion ☐ Other: _____	_____

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ANAPHYLACTIC REACTION (AR):

☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary

☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary

☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access

☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr

☐ Other: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.