



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		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: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION			
<input type="checkbox"/> G36.0 Neuromyelitis optica <input type="checkbox"/> Other ICD-10/Diagnosis: _____ Hepatitis B vaccination: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ - _____ - _____ Hepatitis B screening: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____ - _____ - _____ <input type="checkbox"/> HB core antibody HBcAb+ results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____ - _____ - _____ <input type="checkbox"/> Does the patient have active or latent TB infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis screening: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____ - _____ - _____ First two loading doses completed: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
UPLIZNA® ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Dose	Directions	Refills
<input type="checkbox"/> Uplizna® (inebilizumab injection)	<input type="checkbox"/> 100mg/10mL SDV <input type="checkbox"/> Other: _____	<input type="checkbox"/> Initial Dose: <input type="checkbox"/> Infusion 1: 300mg in 250mL of 0.9% NS. <input type="checkbox"/> Infusion 2: (2 weeks later): 300mg in 250mL of 0.9% NS. <input type="checkbox"/> Other: _____ <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Every 6 months (from first infusion) infuse 300mg in 250mL of 0.9% N <input type="checkbox"/> Other: _____	_____
Pre-medication	Dose/Frequency		Refills
IV Corticosteroids	<input type="checkbox"/> 80mg IV Methylprednisolone <input type="checkbox"/> 125mg IV Methylprednisolone <input type="checkbox"/> Other: _____	<input type="checkbox"/> Prior to each infusion <input type="checkbox"/> Other: _____	_____
Oral Antihistamines	<input type="checkbox"/> 60 mg fexofenadine <input type="checkbox"/> 50 mg diphenhydramine <input type="checkbox"/> Other: _____	<input type="checkbox"/> Prior to each infusion <input type="checkbox"/> Other: _____	_____
Oral Antipyretic	<input type="checkbox"/> 500 mg acetaminophen <input type="checkbox"/> Other: _____	<input type="checkbox"/> Prior to each infusion <input type="checkbox"/> Other: _____	_____

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UPLIZNA®

Please Fax Completed Form To: 888-898-9113

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

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 _____

Prescriber Signature

Date: _____

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.

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