Uplizna® - Inebilizumab Injection

Phone: (346) 708-5160
Fax: (888) 963-8103
www.biotekrx.com

PATIENT INFORMATION (Complete or fax existing chart)	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	State License: _____ NPI #: _____
City, State, Zip: _____	DEA: _____ Phone: _____
Phone: _____ 2nd Phone: _____	Address: _____ Fax: _____
DOB: _____ Gender: ☐ Male ☐ Female	City, State, Zip: _____
Weight: _____ Ht: _____ Date: _____	Contact Person: _____
E-mail address:	Phone:

INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)	
Primary Insurance: _____	RX Card (PBM): _____
City, State, Zip: _____	BIN: _____ PCN: _____
Member ID #: _____ Phone: _____	City, State, Zip: _____
Plan #: _____ Group #: _____	Plan #: _____ Group #: _____

DIAGNOSIS / CLINICAL INFORMATION

Primary ICD-10 code:	**Diagnosis** ☐ G36.0 Neuromyelitis optica	☐ Other:

Is the patient anti-aquaporin-4 antibody positive? ☐ Yes ☐ No ☐ Test pending

Prior NSMOD therapies tried/failed:

Hep B vaccination: ☐ Yes ☐ No **Date:**	Does the patient have active Hepatitis B infection? ☐ Yes ☐ No

Hepatitis B screening: ☐ Hepatitis B surface antigen **HBsAg** results: ☐ 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.

Expected date of first/next infusion:

☐ NKDA ☐ Known drug allergies:

Concurrent Meds:

PRESCRIPTION / ADMINISTRATION

Medication	Dose	Directions	Quantity / Refills
☐ Uplizna® (inebilizumab injection) Initial dose (two infusions) Note: Loading doses must be administered in a controlled infusion site.	100mg/10mL SDV Each dose 300mg/30mL diluted in 250mL of 0.9% sodium chloride injection for final concentration of 1.1mg/mL	Infusion 1: 300mg in 250mL of 0.9% NS. Infusion 2: (2 weeks later): 300mg in 250mL of 0.9% NS. Start infusion at 42mL per hour for the first 30 minutes, increase to 125mL per hour for the next 30 minutes, then increase to 333mL per hour until finished. Duration: 2 hours or longer Monitor patient for at least one hour after infusion completion for infusion reaction.	☐ 6 vials - No refills
☐ Uplizna® (inebilizumab injection) Maintenance dose (one infusion)	100mg/10mL SDV Each dose 300mg/30mL diluted in 250mL of 0.9% sodium chloride injection for final concentration of 1.1mg/mL	Every 6 months (from first infusion) infuse 300mg in 250mL of 0.9% NS. Start infusion at 42mL per hour for the first 30 minutes, increase to 125mL per hour for the next 30 minutes, then increase to 333mL per hour until finished. Duration: 2 hours or longer Monitor patient for at least one hour after infusion completion for infusion reaction.	☐ 3 vials Refills: ☐ 0 ☐ 1

All Uplizna® orders to be administered via pump and peripheral line unless otherwise instructed.

Additional Medication and Supplies for Home Infusion

Premedication Orders

Acetaminophen 650mg PO 30 min prior to infusion; Diphenhydramine 50mg PO 30 min prior to infusion; Methylprednisolone 100mg IV 30 min prior to infusion.
☐ Other:

Fluids for Reconstitution and Administration

0.9% NaCl 250mL x2 (initial dose); 0.9% NaCl 250mL (maintenance dose)
0.9% NaCl Flush 10mL (3 mL pre- and post-infusion to maintain peripheral line patency)

Send quantity sufficient for medication infusion,

All caregivers and ancillaries to be given per protocol from product package insert.

If patient requires specific directions on additional medications or supplies, please provide change on the next page and sign.

0.9% NACL 50mL 0.9% NACL 100mL	

Hypersensitivity / Anaphylaxis Orders*

In the event of anaphylactic reaction, stop infusion of drug immediately. Start NS 15mL/hour; 0.9% NS 100mL.

Medicate with epinephrine pen auto-injector 0.3mg/0.3mL IM as needed for anaphylaxis. Call **911**, physician, or paramedic.

I authorize ancillary supplies or medical equipment necessary such as needles, syringes, etc. to administer the therapy as needed for administration.

☐ Skilled nursing visit as needed to establish venous access, administer medication, and assess general status and response to therapy.
*If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

SIGNATURE

X_____ Date: _____

(Product Substitution Permitted)

Fax completed form to: (888) 963-8103 - Thank you for using BioTek reMEDys®