



Uplizna® - Inebilizumab Injection

Phone: (346) 708-5160

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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: _____ 2 nd Phone: _____	Address: _____ Fax: _____
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> G36.0 Neuromyelitis optica <input type="checkbox"/> Other: _____
Is the patient anti-aquaporin-4 antibody positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Test pending	
Prior NSMOD therapies tried/failed: _____	
Hep B vaccination: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Does the patient have active Hepatitis B infection? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B screening: <input type="checkbox"/> Hepatitis B surface antigen HBsAg results: <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: _____	
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.	
Expected date of first/next infusion: _____	
<input type="checkbox"/> NKDA <input type="checkbox"/> Known drug allergies: _____	
Concurrent Meds: _____	

PRESCRIPTION / ADMINISTRATION			
Medication	Dose	Directions	Quantity / Refills
<input type="checkbox"/> 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.	<input type="checkbox"/> 6 vials - No refills
<input type="checkbox"/> 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.	<input type="checkbox"/> 3 vials Refills: <input type="checkbox"/> 0 <input type="checkbox"/> 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. <input type="checkbox"/> Other: _____	Send quantity sufficient for medication infusion, All caregivers and ancillaries to be given per protocol from product package insert.
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)	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	
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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)

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