VEROS HEALTH
Excellence in Complex Care

Uplizna® (inebilizumab-cdon) Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process

1. PATIENT INFORMATION (*indicates a required field)	2. PHYSICIAN INFORMATION (*indicates a required field)
Name*: ______	Physician's name*: ______
Address*: ______	License #: ______ NPI #*: ______
City*: ______ State*: ______ Zip*: ______	DEA #: ______ Email*: ______
Home Phone: ______ Mobile Phone*: ______	Address*: ______
Email*: ______ Primary language*: ______	City*: ______ State*: ______ Zip*: ______
DOB*: ______ Social Security #*: ______	Office Contact: ______
Gender*: ☐ M ☐ F Height: ______ Weight*: ______	Phone*: ______ Fax*: ______ Specialty*: ______

Allergies*: ______ NKA*: ☐
AQP4 test results ☐ Positive ☐ Negative
Alternate contact name: ______ Alternate contact phone: ______
Consent to leave voice message at the patient and/or alternate contact phone ☐ Yes ☐ No*

3. DIAGNOSIS (*indicates a required field) Year of diagnosis: ______

☐ *ICD10 Code G36.0 Neuromyelitis Optica Spectrum Disorder
☐ Other diagnoses: ______

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION

Anticipated Start Date: ______

Prescription*: Uplizna 100 mg/10 mL (10 mg/mL) solution in a single-dose vial for intravenous use
Prior to administration, dilute Uplizna in 250 mL of 0.9% Sodium Chloride Injection, USP

☐ Initial dose: 300 mg intravenous infusion followed two weeks later by a second 300 mg intravenous infusion
☐ Subsequent doses (starting 6 months from the first infusion): single 300 mg intravenous infusion every 6 months
 # Refills

☐ Pre-medicate with the following at least 30 minutes prior to infusion:
Methylprednisolone ______ mg IV push ***or*** ______
Acetaminophen ______ mg po ***or*** ______
Diphenhydramine ______ mg po ***or*** ______

Additional orders: ______
Access: ☐ Peripheral Other: ______

6. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 mL NS, followed by Heparin 2-5 mL 10 units/mL if indicated
Port: Flush before, after each infusion, and as needed with 5-20 mL NS, followed by Heparin 100 unit/ml 5 mL.

7. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs

8.

PHYSICIAN'S SIGNATURE (required): ______ **Date:** ______

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Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.