

## Uplizna® (inebilizumab-cdon) Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

Referral Process	
<b>1. PATIENT INFORMATION</b> (*indicates a required field)	<b>2. PHYSICIAN INFORMATION</b> (*indicates a required field)
Name*: _____	Physician's name*: _____
Address*: _____	License #: _____ NPI #: _____
City*: _____ State*: _____ Zip*: _____	DEA #: _____ Email*: _____
Home Phone: _____ Mobile Phone*: _____	Address*: _____
Email*: _____	City*: _____ State*: _____
Primary language*: _____	Zip*: _____
DOB*: _____ Social Security #: _____	Office Contact: _____
Gender*: <input type="checkbox"/> M <input type="checkbox"/> F      Height: _____ Weight*: _____	Phone*: _____ Fax*: _____
Allergies*: _____ NKA*: <input type="checkbox"/>	Specialty*: _____
AQP4 test results <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Alternate contact name: _____ Alternate contact phone: _____	
Consent to leave voice message at the patient and/or alternate contact phone <input type="checkbox"/> Yes <input type="checkbox"/> No*	
<b>3. DIAGNOSIS</b> (*indicates a required field) Year of diagnosis: _____	
<input type="checkbox"/> *ICD10 Code G36.0 Neuromyelitis Optica Spectrum Disorder	
<input type="checkbox"/> Other diagnoses: _____	
<b>4. INSURANCE INFORMATION</b> Please submit copies of the front and back of primary and secondary insurance cards with this referral.	
<b>5. PRESCRIPTION INFORMATION</b> Anticipated Start Date: _____	
<b>Prescription*</b> : 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	
<input type="checkbox"/> Initial dose: 300 mg intravenous infusion followed two weeks later by a second 300 mg intravenous infusion	
<input type="checkbox"/> Subsequent doses (starting 6 months from the first infusion): single 300 mg intravenous infusion every 6 months	
<b># Refills</b>	
<input type="checkbox"/> Pre-medicate with the following at least 30 minutes prior to infusion: Methylprednisolone _____ mg IV push <b>or</b> _____ Acetaminophen _____ mg po <b>or</b> _____ Diphenhydramine _____ mg po <b>or</b> _____	
<b>Additional orders</b> : _____	
<b>Access</b> : <input type="checkbox"/> Peripheral    Other: _____	
<b>6. FLUSH ORDERS</b> <b>PIV/midline/PICC</b> : Flush before, after each infusion, and as needed with 3-20 mL NS, followed by Heparin 2-5 mL 10 units/mL if indicated <b>Port</b> : Flush before, after each infusion, and as needed with 5-20 mL NS, followed by Heparin 100 unit/ml 5 mL.	
<b>7. ANAPHYLAXIS ORDERS</b> <b>Adults</b> : 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	
<b>8.</b> <b>PHYSICIAN'S SIGNATURE (required)</b> : _____ <b>Date</b> : _____	