

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



Provider Order Form

Inebilizumab-cdon (Uplizna)

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

ICD-10 code (required): _____ ICD -10 description: _____

NKDA Allergies: _____ Weight lbs/kg: _____

Patient Status: New to Therapy Continuing Therapy Next Due Date (if applicable): Dose/Frequency Change Discontinuation Order

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

Tuberculosis status and date (list results here & attach clinicals)

Quantitative serum immunoglobulin (list results here & attach clinicals):

Hepatitis B status & date (list results here & attach clinicals):

PREN-MEDICATION ORDERS

- acetaminophen (Tylenol) 650mg PO
- diphenhydramine 50mg PO
- methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS (OPTIONAL)

- cetirizine (Zyrtec) 10mg PO
 - loratadine (Claritin) 10mg PO
 - famotidine (Pepcid) 20mg PO
- Other: _____
Dose: _____ Route: _____
Frequency: _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____

THERAPY ADMINISTRATION

- Inebilizumab-cdon (Uplizna) intravenous infusion. Dose: Other _____
- Induction:
 - Dose: 300mg in 250ml 0.9% sodium chloride
 - Frequency: on Day 1 and Day 15
 - Rate: Start at 42ml/hr x30 min, 125ml/hr x 30 min, then 333ml/hr for remainder of infusion
 - Duration should be approximately 90 minutes
 - Administer through an intravenous line containing a sterile, low-protein binding 0.2 or 0.22 micron in-line filter.
 - After induction, continue with maintenance dosing below
- Maintenance:
 - Dose: 300mg in 250ml 0.9% sodium chloride. Dose: Other _____
 - Frequency: every 6 months from the first infusion
 - Rate: Start at 42ml/hr x30 min, 125ml/hr x 30 min, then 333ml/hr for remainder of infusion
 - Duration should be approximately 90 minutes
 - Administer through an intravenous line containing a sterile, low-protein binding 0.2 or 0.22 micron in-line filter.
- Flush with 0.9% sodium chloride at the completion of infusion
- Patient required to stay for 60-min observation post infusion
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Hepatitis B virus, quantitative serum immunoglobulins, and tuberculosis screening is required before the first dose. | Prior to every infusion premedicate with a corticosteroid, an antihistamine, and an antipyretic. | Monitor patients closely during and for at least one hour after infusion.

Provider Name (Print) _____

Provider Signature _____

Date _____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____