

- Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218
- Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030
- NYC Central Park West**
115 Central Park West
Suite 15
New York, NY 10023
- Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225
- Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570
- Woodbury**
75 Froehlich Farm
Woodbury, NY 11797
- Manhattan**
57W 57Street
Suite 601
New York, NY 10019
- Elmsford/Tarrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523
- Staten Island**
27 New Dorp Lane
Staten Island, NY 10306



- Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021
- Holbrook/Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741
- Long Beach**
917 Beech Street
Long Beach, NY 11561
- Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375
- Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583
- Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901
- Manhattan**
225 East 70th Street
New York, NY 10021
- 5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559
- Bronx**
226 West 238th Street
Bronx, NY 10463

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.ixhealth.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 _____