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ThrIVewell™ INFUSION
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Mission Medical

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 _____