Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

NYC

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Southampton
625 Hampton Road
Southampton, NY 11968

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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 _____