

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):

PRE-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 _____