REVITALIZE
INFUSION CENTER

Uplizna®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Neuromyelitis optica ICD-10 Code: G36.0

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Active Medication List
- Relevant labs and tests including:
  - Anti-aquaporin-4 (AQP4) antibody results
- Required Information:
  - Hepatitis B Screening Results
  - Serum Immunoglobulins
  - TB Screening Results

Height: _____

Weight: _____

Uplizna (inebilizumab-cdon) Orders:

☐**New Start**

Administer 300 mg Uplizna intravenously followed by and additional 300 mg Uplizna intravenously two (2) weeks later followed by 300 mg intravenously six (6) months after the initial infusion

3 Doses of 300 mg Authorized

☐ **Maintenance Regimen:**

Administer 300 mg Uplizna intravenously every six months

Doses Authorized: ☐ 6 months (1 dose authorized) ☐ 12 months (2 doses authorized)

Pre-Medication Orders: Acetaminophen 650 mg PO, Diphenhydramine 25 mg PO and Methylprednisolone 80 mg IV administered 30 minutes prior to each infusion *Adjust PRN

☐Other:_____

Lab Orders: ☐ Obtain quantitative IgG & IgM every six months

☐ Serum pregnancy

☐ Other:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus