

Inebilizumab-cdon (Uplizna)

Provider Order Form rev. 8/24/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

- Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)
- Quantitative serum immunoglobulin screening • Hepatitis B results: If Hepatitis B results are positive, provide documentation of medical clearance
- TB Results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

- ☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG) ☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ G36.0 Neuromyelitis optica ☐ D89.84 IgG4-related disease
☐ Other: _____

PRIMARY MEDICATION ORDER

Inebilizumab-cdon (Uplizna) intravenous infusion

- Flush with 0.9% sodium chloride at infusion completion
- Patient required to stay for 60-min observation post infusion
- Rate: Start at 42ml/hr x30 min, 125ml/hr x 30 min, then 333ml/hr for remainder of infusion
- Duration of infusion 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.
- Refill for 12 months unless otherwise noted: _____

☐ **New Start:** 300mg in 250ml 0.9% sodium chloride on day 1 & day 15, then 300mg in 250ml 0.9% sodium chloride every 6 months (starting 6 months from 1st infusion)

☐ **Maintenance:** 300mg in 250ml 0.9% sodium chloride every 6 months

PRE-MEDICATION

Note: Recommendations per PI are selected, these will be given to patient unless otherwise specified.

- ☒ acetaminophen (Tylenol) ☐ 500mg / ☒ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☒ diphenhydramine (Benadryl) ☐ 25mg / ☒ 50mg ☒ PO / ☐ IV
☒ methylprednisolone (Solu-Medrol) ☐ 40mg / ☒ 125mg IV
☐ Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

SPECIAL INSTRUCTIONS

Ordering Provider (Print) _____ Provider Signature _____ Date _____
Ordering Provider (Print) information since the most recent order. If checked, the additional Provider Information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

- ☐ Arbor Infusion Fishers (317) 981-1772