

# Uplizna (inebilizumab-cdon)

Provider Order Form rev. 5/20/2022



www.vascoinfusion.com  
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## PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:	Patient Email:			
NKDA	Allergies:	Weight lbs/kg:	Height:	
<b>Patient Status:</b>	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

## PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

## DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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### ICD-10 CODE

G36.0 Neuromyelitis optica spectrum disorder  
Other: \_\_\_\_\_

### MEDICATION ORDER

**Uplizna** (inebilizumab-cdon)  
Dose: 300mg IV

### PRE-MEDICATION ORDERS (Required)

acetaminophen (Tylenol) 500mg 650mg 1000mg PO  
(30-60 min pre-infusion)

diphenhydramine (Benadryl) 25mg 50mg / PO IV  
(30-60 min pre-infusion)

methylprednisolone (Solu-Medrol) 80mgIV 125mg IV  
(30 min pre-infusion)

Frequency:  
Initial dosing: day 0 and day 15 then every 6 months (starting from first infusion)  
every 6 months

Order Expiration Date (mm/dd/yy): \_\_\_\_\_  
(If not indicated order will expire one year from date signature)

## SPECIAL INSTRUCTIONS

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order