UPLINZA®Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Neuromyelitis optica
_____ Other: _____

Infusion Center Lab Orders (Check order for Infusion center to manage):

☐ Obtain quantitative IgG & IgM every six months
☐ Other: _____

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, Including anti-aquaporin-4 (AQP4) antibody results 4. Recent Lab Results 5. Pre-Screening Documentation including Hepatitis B Screening Results, Serum Immunoglobulins, and TB Screening Results

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **UPLINZA® (inebilizumab-cdon)**

☐ ***New Start:*** 3 Doses of 300 mg Authorized

Administer 300 mg UPLINZA IV followed an additional 300 mg UPLINZA IV 2 weeks later and then a third infusion of 300 mg IV 6 months after the initial infusion

☐ ***Maintenance Regimen:*** _____# Refills (Recommend 1 Refills)

Administer 300 mg UPLINZA IV every six months

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO, Diphenhydramine 25 mg PO and Methylprednisolone 80 mg IV administered 30 minutes prior to infusion **Adjust to patient's needs*

☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date