Mankato Clinic
Together we thrive.

ADULT AMBULATORY INFUSION ORDER
inebilizumab-cdon **(UPLIZNA)**

NAME: _____

BIRTHDATE: _____

Affix Patient Identification Label Here

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Date: _____/_____/_____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Last infusion note ☐ Current Medications

PATIENT INFORMATION

Allergies: _____

Weight: _____ lbs/kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/_____/_____

Phone: (____)_____-_____ Fax: (____)____-_____

Office Address: _____

Contact Person: _____

REQUIREMENTS: PRIOR TO FIRST DOSE OF UPLIZNA

Prescriber typically must indicate that all of the following requirements have been met (attach supporting documentation):

☐ Hepatitis B virus screening **negative**

☐ Active/latent TB screening **negative**

☐ Quantitative serum immunoglobulins **(within normal limits)**

☐ Anti-aquaporin-4 (AQP4) **antibody positive (required)**

☐ Administer immunizations per guidelines **≥4 weeks prior** to initiation of UPLIZNA

If any of the above are NOT checked, attach treatment/consultation notes clearing the patient for inebilizumab-cdon therapy

PRE-MEDICATIONS:

Diphenhydramine: ☐ PO ☐ IV ☐ 25 mg ☐ 50mg

Acetaminophen: ☐ PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

Solu-Medrol: ☐ IV ☐ 125 mg

Other: ☐ _____

☐ No Pre-Medications

☐ 30 minutes wait time following pre-medications

LABS:

☐ CBC w/diff ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ CMP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ CRP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ Urine HCG ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ Other: _____ ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ No labs needed

Uplizna Orders:

- **USE 0.2 MICRON FILTER FOR ADMINISTRATION**

☐ **Loading Dose**: 300 mg IV in 250 mL in Sodium Chloride 0.9% to be infused on day 1 and day 15. Begin infusion at 42 mL/hour for 30 min; increase to 125 mL/hour for 30 minutes; then 333 ml/hr for the remainder of the infusion

☐ **Maintenance**: 300 mg IV in 250 mL in Sodium Chloride 0.9% 6 months after loading dose then every 6 months. Begin infusion at 42 mL/hour x 30 minutes; increase to 125 mL/hour x 30 minutes; increase to a maximum rate of 333 mL/hour for remainder of the infusion.

☐ Patient is required to stay for 60 minute observation post infusion.

☐ Patient is **NOT** required to stay for observation time.