ARJ Infusion SERVICES

Specialty Pharmacy and Nursing

FAX completed form to ARJ 877-451-8955
Intake Specialist 866-451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Uplizna (inebilizumab) I Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with completed order form: (for detailed information refer to Uplizna Ordering Guide below)

☒ Copy of insurance card ☒ Patient demographics ☒ History & physical ☒ Labs (HBV, TB, AQP4, IG levels)

2. Patient Information

☐Male ☐Female Height: _____ in/cm Weight: _____ lbs/kg Allergies: _____
Is this the 1st dose? ☐Yes ☐No, last infusion: _____ Next infusion due: _____ Line type: ☐ PIV ☐PICC ☐Port ☐Other

3. Diagnosis and Clinical Information

Primary diagnosis (required): ☐ Neuromyelitis Optica (G36.0) ☐ Other: _____ ICD-10: _____

4. Prescription Information

Medication	**Uplizna 100mg/10mL single dose vials (3 vials/carton)**
Dosing / Frequency	☐ Initial loading dose: 300mg in 250mL sodium chloride 0.9% on day 0 and on day 15 ☐ Maintenance dose: 300mg in 250mL sodium chloride 0.9% every 6 months (from first infusion) ☐ Loading dose previously completed (2 infusions given 2 weeks apart), provide maintenance dose only
Administration	☒ Infuse intravenously using 0.2 micron in-line filter ☒ Infuse 42mL/hr for the first 30 min, then 125mL/hr for the next 30 min, then 333mL/hr as tolerated
Quantity / Refills	Dispense quantity sufficient for infusion on all selected medications, refill x 12 months Other: _____

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure
☒ **Premedications**: Give 30 to 60 min prior to each infusion
☒ **Diphenhydramine** 25-50mg PO ☒ **Acetaminophen** 650mg PO ☒ **Methylprednisolone** 100mg (**OR** _____mg) slow IVP
☒ RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take diphenhydramine 25-50 mg PO and acetaminophen 325-650 mg PO every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache
☒ RN to monitor patient for 1 hour post infusion. Educate patient on possible side effects, reactions, and when to contact physician
☐Other: _____

6. Adverse Reaction Orders

In the event of an infusion reaction (i.e.: fever, chills, backache, headache) the following orders will be followed, and the physician will be notified. *Note: For mild reactions, patient may be treated, and infusion resumed at a slower rate*
☒ **STOP** infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping the infusion does not resolve symptoms:
☒ Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 min **OR** 50 mg/10 mL NS IV push over 2-3 min
☒ Methylprednisolone 125 mg (**OR** _____ mg) slow IV push over 5 minutes
☒ Epinephrine (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License No.: _____ DEA NO.: _____ NPI: _____

_____ _____ _____ _____
Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

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Uplizna (inebilizumab) Ordering Guide

- For new patients, please submit completed ARJ Uplizna Order Form with all available supporting documentation to facilitate the approval process

- ***Please submit with Uplizna Order Form the following supporting documentation***: *
  - ☐ Progress notes with documentation of diagnosis
  - ☐ Labs and test results supporting primary diagnosis
  - ☐ TB screening (contraindicated in active or untreated latent tuberculosis)
  - ☐ Hepatitis B screening (contraindicated in active hepatitis B infection)
  - ☐ AQP4 seropositive lab result
  - ☐ Serum immunoglobulins
  - ☐ Medication history including prior and/or concurrent NMOSD therapies

  **Specific plans may require additional documentation for prior authorization.*

- Additional information for consideration:
  - Uplizna may be administered in a patient's home or in an ARJ infusion suite, per individual insurance plan
  - Patients should be up to date on guideline recommended vaccination schedules at least 4 weeks prior to initiating Uplizna. Live or live-attenuated vaccinations are not recommended during treatment or after treatment discontinuation (until B-cell repletion)
  - Serum immunoglobulins are recommended to be assessed at the beginning of treatment, during treatment, and after discontinuation of Uplizna (until B-cell repletion)
  - Lab draws will need to be arranged at prescriber's office or a lab facility of patient's preference

- Resources:
  - Provider to enroll patient in Horizon By Your Side patient support program on the Uplizna website [UPLIZNA-Patient-Enrollment-Form.pdf (hzndocs.com)]. This is not required but highly recommended to provide patients with support throughout therapy, including manufacturer resources if needs arise
  - For expedited access to therapy, Uplizna Starter Bridge Program is available for eligible patients on manufacturer website [UPLIZNA-Starter-Bridge-Program.pdf (hzndocs.com)]