

UPLIZNA (inebilizumab-cdon) ORDER FORM

PATIENT NAME: _____ DOB: _____ WT: _____ HT: _____

ALLERGIES: _____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: **UPLIZNA (inebilizumab-cdon)** NO YES - LAST DOSE DATE: _____

DIAGNOSIS: _____ ICD 10 CODE(S): _____

MEDICATION ORDERS

DOSE/FREQUENCY: Orders are valid for 1 year. For a shorter duration, indicate here: _____

- 300 mg IV on day 1, then 300 mg IV 2 weeks later, then 300 mg IV every 6 months (beginning 6 months after the 1st 300 mg dose)
- 300 mg IV every 6 months
- Other: _____

PREMEDICATION (REQUIRED PER PACKAGE INSERT): 30 to 60 minutes prior to infusion

Per UPLIZNA package insert, premedications MUST include a corticosteroid, an antihistamine, and an antipyretic

- | | | |
|---|---|---|
| <input type="checkbox"/> Methylprednisolone 125 mg IV | <input type="checkbox"/> Diphenhydramine 50 mg IV | <input type="checkbox"/> Acetaminophen 1000 mg PO |
| <input type="checkbox"/> Methylprednisolone 100 mg IV | <input type="checkbox"/> Diphenhydramine 25 mg IV | <input type="checkbox"/> Acetaminophen 500 mg PO |
| <input type="checkbox"/> Other (drug/dose/route): _____ | | |

STANDARD ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify provider.
- Observe patient for 60 minutes after completion of therapy.

LABS

LAB ORDERS:

- CBC w/diff CRP
- Other: _____

LAB FREQUENCY:

- Every dose
- Other: _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- Hepatitis B serology labs or proof of immunity/vaccination
- QuantiFERON Gold lab result for TB screening
- Serum Immunoglobulin labs

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Review that all age-appropriate vaccinations are up-to-date as per current immunization guidelines (Live and live-attenuated vaccines are not recommended during UPLIZNA therapy—give these at least 4 weeks prior to initiation)
- Pregnancy test in females of reproductive age

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

 PRESCRIBER SIGNATURE (substitution permitted)

 PRESCRIBER SIGNATURE (dispense as written)

 PRINT NAME (FIRST AND LAST)

 DATE