UPLIZNA ORDERS

Please complete ALL fields and fax to 817-553-1393. An incomplete form will delay the processing/scheduling of the patient. Thank you for your referral and allowing us to partner with you in the care of your patient. Please call 817-553-1325 with any questions.

Patient Name: _____DOB: _____

Phone: _____Allergies: _____

Weight: _____ ❑ lbs/❑ kg

Primary Diagnosis: _____ ICD-10 Code: _____

Please send all of the following items to complete your referral:

- ❑ This completed order form
- ❑ Patient demographics and insurance information
- ❑ List of tried and failed medications for this diagnosis along with dates taken and reason for failure or intolerance
- ❑ Any other relevant lab work, scan or test results- Quantitative immunoglobulins within normal limits. Latent TB screening negative. Anti-aquaporin-4 (AQP4) antibody positive (required) . HBV screening negative.

Prescription: (*ORDER EXPIRES IN ONE YEAR)

- Start Peripheral IV Saline lock.
- Flush IV line with 3 to 10ml 0.9% Sodium Chloride before and after IV medication administration.
- Pre-medications: give 30 minutes before starting Uplizna
    1. Acetaminophen 500 mg PO
    2. Diphenhydramine 25mg PO
    3. Methylprednisolone 125mg IV

❑ Infuse UPLIZNA 300 mg IV in 250 ml 0.9% Sodium Chloride Solution, USP. Flush line with 20 ML 0.9% Sodium Chloride Solution, USP after Uplizna completion. Monitor patient one hour after each infusion. Infuse day 1 and day 15. Repeat in 6 months from day 1. Repeat every 6 months thereafter.

❑ Other orders:_____

Ordering Provider Information

Name _____

Address _____

_____

NPI # _____

Signed _____

Office Contact Information

Name _____

Phone ( ) _____-_____

Fax ( ) _____-_____

Email _____

Date _____ /_____ /_____