INTRAMED Plus
infusion services

# UPLIZNA®

## INFUSION & MEDICAL CENTER

**1. Patient Name** _____ **DOB** _____ **Patient Phone/Cell #** _____

**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: _____ Neuromyelitis optica ICD-10 Code: G36.0.

_____ Other:_____ ICD-10 Code: _____

Allergies:_____ (or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Including anti-aquaporin-4 (AQP4) antibody results
- Pre-Screening Documentation including Hepatitis B Screening Results, Serum Immunoglobulins, and TB Screening Results
- Medication List

**Patient**
**Weight:** _____ lbs.
**Height:** _____ in.

**4. Lab Orders:** ❑ Obtain quantitative IgG & IgM every six months

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### UPLIZNA® (inebilizumab-cdon) J Code: J1823

**5. Drug Order:**

❑ **New Start:**

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

3 Doses of 300 mg Authorized

❑ **Maintenance Regimen:**

Administer 300 mg UPLIZNA IV every six months _____ # Refills (Recommend 1 Refills)

**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

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

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**6. Physician Signature:** _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____ Contact Phone #: _____

| FAX ALL INFORMATION | CENTRAL INTAKE PHONE |
|---|---|
| CENTRAL FAX **803.999.1754** | **803.999.1750** |