Inebilizumab-cdon (Uplizna)

Provider Order Form rev. 03/20/2026

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Neuromyelitis Optica spectrum disorder with AQP4 positive antibodies:

Generalized Myasthenia Gravis (gMG):

Immunoglobulin G4-Related Disease (IgG4-RD)**:**

Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Induction: Administer Uplizna 300mg IV at week 0, followed by 300mg IV at week 2

☐ Maintenance: Administer Uplizna 300mg IV every 6 months *(beginning 6 months after first dose)*

☑ Dilute in 250ml NS, do not shake

☑ Monitor patient for 1 hour post infusion for signs and symptoms of adverse reaction

☑ Infuse at progressive rate listed below over 90 mins:

Elapse Time (minutes)	Infusion Rate (ml/hr)
0-30mins	42ml/hr
31-60mins	125ml/hr
61-90mins	333ml/hr

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☑ Administer all premedication 30minutes prior to infusion

☑ Required Tylenol 650mg PO

☑ Required Solumedrol 125mg IV

☑ Required Benadryl 25 mg- 50mg ☐ PO / ☐ IV

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for signs or symptoms of active infection/Recent live vaccine or suspected pregnancy

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECK LIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. Hepatitis B virus, quantitative serum immunoglobulins, and tuberculosis screening is required before the first dose for all patients. Diagnosis specific requirements: NMOSD: AQPR antibody labs, TF to steroids. Ig4-RD: radiographic confirmation of diagnosis, TF to steroids. gMG: AchR antibody labs and/or MuSK antibody labs. May also require MG disease classification, MG-ADL score, TF to steroids, Immunosuppresants and/or Mestinon

Required Labs: Hepatitis B results, TB test results, quantitative serum immunoglobulins. Diagnosis specific labs.

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.