inebilizumab-cdon (Uplizna®) Order Form **FAX to 1 (888) 797-4008**

PATIENT INFORMATION		
Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena? ☐ Yes ☐ No		

Order date:	Weight:	Height:
Drug allergies: ☐ NKDA. ☐ YES. Please specify.		
ICD-10 diagnosis:		

LABORATORY DATA		
CBC:	BMP:	Anti-AQP4 Ab:
Quantitative serum immunoglobulin:		Other:

Hepatitis Screen			
HBsAg: ☐ Pos ☐ Neg	HBsAb: ☐ Pos. ☐ Neg	HBcAb: ☐ Pos. ☐ Neg	Date:

TB Screen

TST (PPD): ☐ Not done ☐ 5-9 mm ☐ 10-14 mm ☐ ≥ 15 mm Date of test:

IGRA: ☐ Not done ☐ Positive ☐ Negative ☐ Indeterminate/Borderline Date of test:

inebilizumab-cdon (Uplizna®)		
Dose	**Directions**	**Refills**
☐ 300 mg IV	☐ once at day 1 and at day 15	
☐ 300 mg IV	☐ once q 6 months after day 1	

Pre-medications		
acetaminophen (Tylenol®)	CH3-prednisolone (Solu-medrol®)	diphenhydramine (Benadryl®)
☐ 500 mg	☐ 80 mg	☐ 25 mg
☐ 650 mg	☐ 125 mg	☐ 50 mg
☐ Other	☐ Other	☐ Other

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.