

Uplizna® (Inebilizumab-cdon) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code: G36.0 ICD-10 Code(s): _____

Is this the first dose? Yes - Date of first dose _____ No - Date of next dose _____

Hepatitis B Status: Titer Date: _____ Positive Negative

TB Status PPD (negative) – date: _____ Active TB Unknown

Last chest x-ray – date: _____ Other _____

Past positive TB infection, course taken: _____

Uplizna® Prescription

Uplizna® (Inebilizumab-cdon) refill as directed x 1 year

Froedtert Specialty Infusion to initiate services beginning with dose number _____ as indicated below:

Dose 1: Infuse 300mg. Administer diluted infusion over approx. 90 minutes at an increasing rate. Use a 0.2 or 0.22 micron in-line filter.
Start by infusing 42ml/hr for the first 30 min, followed by a rate of 125ml/hr for the next 30 min. Increase to 333ml/hr until completion.

Dose 2: (2 weeks after dose 1) Infuse 300mg over 90 minutes at above increasing rate.

Subsequent doses: (every 6 months starting 6 months from the first infusion). Infuse 300mg over 90 min at the increasing rate.

Withdraw 10ml from each of three 100mg/10ml vials (total 30ml) and add contents to 250ml of 0.9% sodium chloride ONLY.

Prior to every infusion, assess for active infection and delay infusion as appropriate.

Ancillary Orders

Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol.

Pre-Medication Orders

Pre-medicate with a corticosteroid, antihistamine, and antipyretic.

Methylprednisolone _____ mg IV given 30 min prior to infusion.

Diphenhydramine _____ mg PO 30-60 min prior to infusion. Patient may decline.

Acetaminophen _____ mg PO 30-60 min before infusion. Patient may decline.

Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

Lab Orders

No labs ordered at this time.

Quantitative serum IG levels. Specify date and/or frequency: _____

Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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Menomonee Falls, WI 53051

03/25

262-532-5040