ACTIVE infusions

UPLIZNA (inebilizumab-cdon) ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____
Patient Status: □ New to Therapy □ Continuing Therapy **Next Treatment Date:** _____
Patient Weight: _____ lbs./kg. (required) Allergies: _____

MEDICAL INFORMATION

Diagnosis: □ Neuromyelitis Optica Spectrum Disorder (NMOSD) — AQP4 antibody positive □ IgG4-Related Disease (IgG4-RD)
□ Generalized Myasthenia Gravis (gMG) AChR or MuSK antibody positive □ Other: _____
ICD-10 Code: _____

THERAPY ORDER

Uplizna:
□ Initial Dose: 300 mg IV infusion at Week 0, followed by a second 300 mg IV infusion 2 weeks later (Week 2). Then 300 mg IV every 6 months thereafter x 1 year.
□ Maintenance Dose: 300 mg IV every 6 months x 1 year.

Premedication Protocol (required prior to each infusion):
Administer ALL three premedications 30–60 minutes before each infusion:

Corticosteroid	Antihistamine	Antipyretic
□ Methylprednisolone 125 mg IVP □ Other: _____	□ Diphenhydramine 25 mg PO/IV □ Cetirizine 10 mg PO □ Other: _____	□ Acetaminophen 650–1000 mg PO □ Other: _____

Additional premedications: □ Solu-Medrol _____ mg IVP □ Solu-Cortef _____ mg IVP □ Other: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

□ Signed and completed order form
□ Patient demographic information and insurance information
□ Patient medication list
□ Supporting clinical notes (H&P) to support primary diagnosis

Has the patient tried and failed previous drug therapy? If yes, which drugs? _____

□ Labs **Attached:**
- □ AQP4 antibody (NMOSD orders)
- □ AChR antibody or MuSK antibody (gMG orders)
- □ Hepatitis B surface antigen (HBsAg) and Hepatitis B core total antibody (HBcAb) — required before first dose
- □ Quantitative serum immunoglobulins — required before first dose
- □ Tuberculosis (TB) screening — required before first dose
- □ IgG4 serum level and tissue biopsy confirmation (IgG4-RD orders)
- □ Other supporting labs based on diagnosis/order

□ Diagnostic **Testing:**
- □ MRI documentation (NMOSD and gMG orders)
- □ Other diagnostic testing to support diagnosis/order

□ Vaccination record — all immunizations must be up to date at least 4 weeks prior to initiating Uplizna (live or live-attenuated vaccines)
□ Medical necessity documentation — prior treatment history, intolerance, or contraindication to previous therapies as applicable

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance

PROVIDER INFORMATION

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____