



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 |
|---|---|--|
| <input type="checkbox"/> Methylprednisolone 125 mg IVP <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Diphenhydramine 25 mg PO/IV <input type="checkbox"/> Cetirizine 10 mg PO <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Acetaminophen 650–1000 mg PO <input type="checkbox"/> 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: _____

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

Phone Call Text Message Email No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder?

Yes No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION