

UPLIZNA INFUSION ORDER (Inebilizumab-cdon)



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Date: ___/___/___

PATIENT INFORMATION

Patient Name: _____ DOB: ___/___/___ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

Labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

PRE-MEDICATIONS (30 MINUTES BEFORE INFUSION)

Solu-Medrol:	<input type="radio"/> IV	<input type="radio"/> 80mg	<input type="radio"/> 125mg
Acetaminophen	<input type="radio"/> PO	<input type="radio"/> 500mg	<input type="radio"/> 650mg
Diphenhydramine:	<input type="radio"/> PO	<input type="radio"/> 25mg	<input type="radio"/> 50mg

UPLIZNA (INEBILIZUMAB-CDON) IV DOSAGE

UPLIZNA IV LOADING DOSAGE:

200 mg in 250 mL 0.9% Sodium Chloride on day 1 and day 15

UPLIZNA IV MAINTENANCE DOSAGE:

300 mg in 250 mL 0.9% Sodium Chloride 6 months after loading dose, then every 8 months.

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: ___/___/___

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990

FAX: 972-810-0994