Inebilizumab-cdon (Uplizna)

Provider Order Form rev. 03/20/2026

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Neuromyelitis Optica spectrum disorder with AQP4 positive antibodies:

Generalized Myasthenia Gravis (gMG):

Immunoglobulin G4-Related Disease (IgG4-RD):

Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Induction: Administer Uplizna 300mg IV at week 0, followed by 300mg IV at week 2

☐ Maintenance: Administer Uplizna 300mg IV every 6 months *(beginning 6 months after first dose)*

☑ Dilute in 250ml NS, do not shake

☑ Monitor patient for 1 hour post infusion for signs and symptoms of adverse reaction

☑ Infuse at progressive rate listed below over 90 mins:

Elapse Time (minutes)	Infusion Rate (ml/hr)
0-30mins	42ml/hr
31-60mins	125ml/hr
61-90mins	333ml/hr

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☑ Administer all premedication 30minutes prior to infusion

☑ Required Tylenol 650mg PO

☑ Required Solumedrol 125mg IV

☑ Required Benadryl 25 mg- 50mg ☐ PO / ☐ IV

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for signs or symptoms of active infection/Recent live vaccine or suspected pregnancy

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECK LIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. Hepatitis B virus, quantitative serum immunoglobulins, and tuberculosis screening is required before the first dose for all patients. Diagnosis specific requirements: NMOSD: AQPR antibody labs, TF to steroids. Ig4-RD: radiographic confirmation of diagnosis, TF to steroids. gMG: AchR antibody labs and/or MuSK antibody labs. May also require MG disease classification, MG-ADL score, TF to steroids, Immunosuppresants and/or Mestinon

Required Labs: Hepatitis B results, TB test results, quantitative serum immunoglobulins. Diagnosis specific labs.

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.