Cosibelimab-ipdl (Unloxcyt)

Provider Order Form rev. 03/26/2026

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)*

Metastatic cutaneous squamous cell carcinoma (mCSCC):

Locally advanced CSCC (laCSCC):

Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Administer UNLOXCYT 1,200 mg as an intravenous infusion every 3 weeks
☑ Dilute in 250ml NS, do not shake
☑ Infuse over 60 mins

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20 mg
☐ Benadryl ☐ 25 mg / ☐ 50 mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40 mg / ☐ 125 mg IVP
☐Other: ______________________________

ADDITIONAL ORDERS

LABORATORY ORDERS

☐	CBC w/ diff	☐ at each dose	☐ every: ______
☐	CMP	☐ at each dose	☐ every: ______
☐	LFTs	☐ at each dose	☐ every: ______
☐	CrCl	☐ at each dose	☐ every: ______
☐	TSH	☐ at each dose	☐ every: ______
☐	Other: ____________________________		

NURSING

☑ Hold infusion and notify provider for signs or symptoms of active infection, received or plan to receive an organ or stem cell transplant, suspected pregnancy, or breast feeding.
☑ 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 CHECKLIST *(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. Patient is not a candidate for curative surgery or curative radiation.

Required Labs: LFTs, CrCl, Thyroid function, and negative pregnancy test.

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.