Uplizna®

Referring Physician Orders Rev. 3/2025

Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card* front and back *(required)

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

DIAGNOSIS*

ICD-10 CODE *(required)* ***Please complete 2nd and 3rd digits to complete ICD-10 for billing***

☐ Neuromyelitis Optica G36.0
☐ IgG4-Related Disease (IgG4-RD) D89.84
☐ Other: _____, ICD-10 _____
☐ Myasthenia Gravis without (acute) exacerbation, G70.00
☐ Myasthenia Gravis with (acute) exacerbation, G70.01

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Uplizna® (inebilizumab)	300mg	☐ Inital: Infuse IV over 90 minutes every 2 weeks x 2 doses. ☐ Maintenance: Infuse IV over 90 minutes every 6 months x 1 year.

Observe patient for 1 hour after completion of infusion.

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time ☐ Diphenhydramine 25mg PO ☐ Other: _____

☐ Acetaminophen 650mg PO ☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS *(required)*

- Hepatitis B Screening for Ocrevus (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by: ☐ Infusion Center ☐ Referring Physician
- Meningococcal vaccination for Soliris (must be completed at least 2 weeks prior to starting therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For ALS:
☐ ALS Functional Rating Scale-revised (ALSFRS-r)
☐ Pulmonary function test

For CIDP:
☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ Lumbar puncture test
☐ Nerve biopsy report
☐ Neurological Rankin Scale Score

For MMN:
☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ anti-GM1 antibodies
☐ Lumbar puncture test

For Myasthenia Gravis:
☐ Acetylcholine receptor (AChR) antibodies
☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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