



A Carelon Company

UPLIZNA (INEBILIZUMAB) INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				
Diagnosis Code ICD-10 (required):			Diagnosis Description:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy			Next Treatment Date:	

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:	
Office Contact:		Email:		
Address:		City:	State:	ZIP:
NPI #:	DEA#:	Tax ID:		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Medication Orders	Refills
Uplizna (inebilizumab)	<input type="checkbox"/> Initial dosing: 300mg IV followed by 300mg IV 2 weeks later, then 300mg IV every 6 months (starting 6 months from the first infusion) <input type="checkbox"/> 300mg IV every 6 months	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Protocol Pre-Medications: Solu-Medrol 125mg IV, diphenhydramine 25mg PO, and acetaminophen 650mg PO to be given 30 minutes prior to infusion (if no contraindications)

Other orders: _____

Lab Orders: _____ Frequency: _____

Required labs to be drawn by Infusion Center Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PRESCRIBER SIGNATURE By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:** _____

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's current medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

For NMOSD (required), please answer:

- Has the patient had a documented contraindication/intolerance or failed trial of rituximab, azathioprine, or mycophenolate mofetil? Yes No
- Does the patient have a history of at least one relapse (acute attack from neuromyelitis spectrum disorder) in the last 12 months, or two relapses in the last 2 years? Yes No
- Expanded Disability Status Score (EDSS): _____

For IgG4-RD (required), please answer:

- ACR/EULAR IgG4-RD Classification Criteria Score: _____
- Has the patient had a documented contraindication/intolerance or failed trial of rituximab, steroid, or immunosuppressant? Yes No
- If yes, which drug(s): _____

For gMG (required), please answer:

- MG-ADL score: _____
- MGFA clinical classification (I, II, III, IV, V): _____
- Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids, or acetylcholinesterase inhibitors)? Yes No If yes, which drug(s)? _____

- Include **labs** (i.e., IgG4) and/or test results to support diagnosis
- Other medical necessity: _____
- Prescriber - please enroll patient in the manufacturer HUB program

REQUIRED PRE-SCREENING

- TB screening test completed within 12 months**
 - Positive Negative
- Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM)**
 - Positive Negative
- Serum immunoglobulins**
- AQP4 positive antibody lab (NMOSD diagnosis)**
- MuSK or AChR positive antibody lab (gMG diagnosis)**