



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:				
<b>Diagnosis Code ICD-10 (required):</b>			<b>Diagnosis Description:</b>	
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
<b>Uplizna</b> (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)**