Ascension St. Vincent's

Outpatient infusion center
Phone 904-296-5994 Fax 904-296-9070

Patient Name: _____
Date of Birth: _____
Patient Phone number: _____
Insurance: _____
Subscriber ID: _____
Infusion Site: _____

Inebilizumab (Uplizna) Order Set

Fill out all information on this form and attach the following as appropriate:

-Copy of prescription/medical card (front and back)
-Pertinent labs related to diagnosis and medication administration
-Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	Weight	_____ kg	Allergies	☐ NKDA	☐ List:_____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐Neuromyelitis optica spectrum disorder ☐Immunoglobulin G4 related disease ☐ Other:_____	☐ G36.0 ☐ D89.84 ☐ Other:_____	☑ J1823	☑ CPT Code: _____

Labs (prior to scheduling initial infusion)

Prior to initiation:
☑ Administer all vaccines at least 4 weeks prior to initiation
☑ Tb screen (active and latent)
☑ Quantitative serum immunoglobulins
☑ Hepatitis B virus ((hepatitis B surface antigen and anti-hepatitis B core antibody measurements)
☑ CBC with differential

Maintenance labs:Blood tests every 4 weeks for the first 3 months, followed by three months
☑ CBC with differential
☑ Quantitative serum immunoglobulins
☑ CD19/20-positive B-cells count

Other Labs:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Nursing Orders

☑ Monitor infusion reactions during and for at least 1 hour following end of the infusion
☑ Assess for active infection prior to each infusion. Hold infusion and call provider if any infection is present.
☑ Assess for progressive multifocal leukoencephalopathy (eg, progressive weakness on one side of the body or clumsiness of limbs, vision disturbance, and changes in thinking, memory, and/or orientation leading to confusion and personality changes). If positive, hold infusion and call provider.
☑ Discharge patient when stable and meets protocol criteria

Emergency/Anaphylaxis Order

☑ Follow standard orders for management of allergies and anaphylaxis reactions

Pre-medications (not required)

☑Acetaminophen 650 mg PO, once
☑Diphenhydramine 25 mg PO, once
☑ Dexamethasone 20 mg IV, once
☐ Cetirizine 10 mg PO, once
☐ Ondansetron 4 mg IV, once
☐ Diphenhydramine 25 mg IV, once
☐ Other: _____
☐ Other: _____

Medication Orders

	Medication	**Route**	**Dose**	**Frequency**	**Select Treatment Type**
☑	Inebilizumab (Uplizna)	IV	300 mg	Once	☐ Initiation and maintenance regimen: 300 mg on day 1, followed by 300 mg 2 weeks later; subsequent doses of 300 mg are administered once every 6 months (beginning 6 months after the first 300 mg dose) ☐ Maintenance only: Every 6 months x ____ dose (s) ☐ Other:_____

Order Comments: Administer diluted infusion over ~90 minutes at an increasing rate: 42 mL/hour for first 30 minutes, followed by 125 mL/hour for the next 30 minutes, then 333 mL/hour until completion using a low-protein binding 0.2 or 0.22 micron in-line filter. Assess for active infection; if present, delay infusion until infection resolves. Premedicate with antihistamine, antipyretic, and corticosteroid 30 to 60 minutes prior to infusion.

Infusion Center Staff Please fax infusion records or discharge summary to:	**Fax Number**_____

Provider Signature		**Date**	
Provider Printed Name			