Comanche County Memorial Hospital

Outpatient Infusion Center
Uplizna Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender M F

Patient Address: Email: Insurance:

Additional Information Needed

Fax front/back of insurance card
Fax clinical/progress notes
Fax labs
Fax patient demographics
Fax current medication list
Fax TB and Hap B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

G36.0 Neuromyelitis Optica Spectrum Disorder

Other DX: ____________________

Clinical Information:

New Therapy Induction
Therapy Change
Therapy Continuation

Patient Weight: __________ lbs/__________ kg
Patient Height: ________ in/ __________ cm

Allergies: ____________________

Therapies Tried and Failed: ____________________

Does the patient have venous access? Yes or No
If yes, What type? __________
If no, Initiate IV access

Prescriber must indicate all of the following have been met (attach supporting documentation) If any box below not checked, attach notes clearing patient for therapy

Latent TB screening **negative**
Hep B screening **negative**
quantitative immunoglobulins **within normal limits**
anti-aquaporin-4 (AQP4) antibody **positive (required)**

Pre-Infusion:

Assess for contraindications; HOLD infusion and notify provider for :

- signs/symptoms of active infection
- planned or recent invasive/surgical procedure
- vaccination (live or live-attenuated) within 4 weeks
- chance of pregnancy
- signs/symptoms of PML (new or worsening unilateral weakness, confusion, changes in vision thinking, memory, balance or personality/mood)

Pre-Medications

Benadryl	________ mg	PO	IVP	once	30	min prior to infusion
Acetaminophen	________ mg	PO	IVPB	once	30	min prior to infusion
Methylprednisolone	________ mg	PO	IVP	once	30	min prior to infusion

Lab Orders

CBC w/out diff CMP ESR CRP

Other: ____________________

Lab Orders to be done by

Infusion Services
Referring Provider

Prescription Information

Uplizna Dose: 300 mg/30 ml in 250 ml 0.9% NaCl

Administer using 0.2- or 0.22-micron filter

Elapsed Time (minutes)	Infusion Rate
0-30	42 ml/hr
31-60	125 ml/hr
61 to completion	333 ml/hr

Frequency

On Day 1 and Day 15; repeat in 6 months (from day 1)
Every 6 months (date of last treatment: __________)

Misc Orders

Obtain vital signs at baseline, with rate changes, immediately post infusion and at discharge

PICC/Midline/CAD dressing to be changed every 7 days

Monitor patient for hypersensitivity reaction for 60 minutes following infusion

____

Flushes

10mL NS Flush Syringe PRN
Heparin 500units/5mL Flush Syringe PRN
50ml NS Bag PRN
250ml NS Bag PRN

Standing Orders for Adverse Reactions

Stop infusion and initiate NS bolus
Notify Supervising physician and ordering provider
Solu-Cortef 100mg SIVP signs of adverse reaction
Benadryl 25mg SIVP for hives or bronchial inflammation
Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
Oxygen 2-5L nasal cannula
Albuterol 2.5mg inhaled PRN for chest tightness
Other: ____________________

Prescriber Information

Physician Name: ____________________ Office Contact Name: ____________________
Contact #: ____________________ Fax Number: ____________________
Address: ____________________ City/State/Zip: ____________________
NPI#: __________ DEA#: __________ State License #: ____________________

____________________ ____________________

Physician's Signature Date Time