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