

Uplizna® Enrollment Form

 Fax Referral To: 877-828-3941
 Phone: 877-828-3940
 referrals@infucarerx.com
 www.infucarerx.health

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: Patient MD Office Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS	MEDICAL HISTORY				
D89.84 IgG4-RD (immunoglobulin G4-related disease) G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD) G70.00 Myasthenia Gravis without (acute) exacerbation G70.01 Myasthenia Gravis with (acute) exacerbation	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: right;">Therapy:</td> <td style="text-align: center;">New</td> <td style="text-align: center;">Reauthorization</td> <td style="text-align: center;">Restart</td> </tr> </table> Date of last infusion with Uplizna® if applicable: _____ Patient Weight: _____ kg lbs Height: _____ cm in Allergies: _____ Concomitant medications: _____ Cormorbidities: _____ Demographics / H&P / Prescription / Insurance Information attached Screenings required before the first dose: Please include with clinical records Hepatitis B virus Date: _____ Contraindicated if HBV is positive TB Date: _____ Quantitative serum immunoglobulins Date: _____ Type of IV access if applicable: _____ Delay infusion if active infection	Therapy:	New	Reauthorization	Restart
Therapy:	New	Reauthorization	Restart		
IgG4-RD Indication: Confirmed dx by either radiologic or pathologic involvement from the following organs: Pancreas Salivary gland Bile ducts Orbits Kidney Lung Aorta Retroperitoneum Pachymeninges Thyroid gland History of IgG4-RD affecting at least 2 organ sites at any time. NMOSD Indication: AQP4 (anti-aquaporin-4) antibody test included in the referral Member exhibits one of the following core clinical characteristics of NMOSD: Optic neuritis Acute myelitis Symptomatic cerebral syndrome with NMOSD-typical brain lesions Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting) Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic magnetic resonance imaging (MRI) lesions Will not be used with other biologics. MG Indication: Positive AChR (acetylcholine receptor) and/or MuSK (anti-muscle specific tyrosine kinase) antibody test included with clinical records MG-ADL Score: _____ MGFA classification: _____ Date of diagnosis: _____ List all previous therapies: _____					

PRESCRIPTION INFORMATION

Uplizna® Drug/Strength (100mg/mL vial): Initial Dose: 300mg on Day 1 and 300mg on Day 15 Maintenance Dose: 300mg every 6 months starting 6 months after first infusion	Directions: Administer IV over 90 minutes via Curlin Pump with 0.2 or 0.22 micron inline filter starting at 42mL/hr for 30 minutes, 125mL/hr for the next 30 minutes and for the remainder of the infusion. **Monitor during the infusion and for at least 1 hour following the infusion	Quantity/Refills: Initial: 300mg x2 doses Maintenance: 300mg x _____ refills(s)
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PREMEDICATION ORDERS/OTHER MEDICATIONS

► Premedications standing order: Please specify if alternatives required:

Dispense quantity sufficient with Uplizna® doses: Diphenhydramine PO 25 mg or _____ Acetaminophen PO 650mg or _____ Methylprednisolone IV push 80mg or _____	Directions: 30 to 60 minutes prior to infusion 30 to 60 minutes prior to infusion slow IV push over 3 minutes 30 minutes prior to infusion	► Infusion supplies as per protocol ► Anaphylaxis Kit orders as per protocol ► Flush orders as per protocol
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ADDITIONAL COMMENTS:

Prescriber Signature: _____ Date: _____



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