**BIOCARE INFUSION**
**ONCOLOGY & THERAPEUTICS**

# UPLIZNA
# INFUSION ORDERS

**FAX:** 470.922.3656 | **PHONE:** 470.377.6400

## PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

## MEDICAL INFORMATION

**Diagnosis:** ☐ Neuromyelitis optica spectrum disorder (ICD-10 Code: G36)

☐ Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs. Allergies: _____

## THERAPY ORDER

**Uplizna**

☐ Initial dosing: 300mg IV followed by 300mg IV 2 weeks later, then 300mg IV every 6 months (starting 6 months from the first infusion) x 1 year

☐ 300mg IV every 6 months x 1 year

**Protocol Pre-Medication Orders:** Solu-Medrol 125mg IV, Benadryl 25mg PO, and Tylenol 650mg PO to be given 30 minutes prior to infusion (if no contraindications)

Other orders: _____

**Lab Orders:** _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

**Anaphylactic Reaction Orders**:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or SubQ; may repeat in 5-10 minutes x 1
  - 15-30kg (33-66 lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
- Diphenhydramine: Administer 25-50mg PO or IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

**Flush orders:** NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

## PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* 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

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

## PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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# COMPREHENSIVE SUPPORT FOR UPLIZNA THERAPY

## PATIENT INFORMATION:

Patient 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

- ☐ 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): _____

☐ Include labs and/or test results to support diagnosis

☐ Other medical necessity: _____

## REQUIRED PRE-SCREENING

☐ **TB screening test completed within 12 months - attach results**
☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - attach results**
☐ **Positive** ☐ **Negative**

☐ **Serum immunoglobulins - attach results**

☐ **AQP4 positive antibody lab - attach results**

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance**