Rocky Mountain
Multiple Sclerosis Clinic

Uplizna Order Set

Phone: (801) 331-9660
Please fax signed order, clinicals, and recent labs to:
RMM - Salt Lake City Fax: (844) 670-3765 | **RMM - Lehi Fax:** (844) 670-3776

Patient Information		
Patient Name:		Order Date:
DOB:	Ht:	Wt:
Allergies:		
Diagnosis:		ICD-10 Code:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:

Lab Orders	**Pre-Medication Orders**
☐ CBC w/diff and Platelets ☐ CMP ☐ HBsAg and anti-HBc ☐ Pregnancy Test ☐ UA ☐ Other: _____ Frequency: ☐ Every Infusion ☐ Other:	☐ Methylprednisolone 125mg IVP over 5 min; Administer 30 min prior to infusion Diphenhydramine PO 25 mg ☐ or 50 mg ☐ PO 30-60 min prior; may repeat x1 in 4 hours Diphenhydramine IVP 25 mg ☐ or 50 mg ☐ IVP 30-60 min prior; may repeat x1 in 4 hours Cetirizine ☐ 10 mg PO or ☐ Cetirizine 10 mg IVP 30 minutes prior to infusion. ☐ Famotidine 20 mg IVP 30 minutes prior to infusion. ☐ Acetaminophen 650 mg PO 30 minutes prior to infusion. May repeat x1 in 4 hours. ***Protocol for Uplizna:*** Methylprednisolone, acetaminophen, and diphenhydramine administered 30 minutes before infusion. (if no contraindications)
Other Orders & Notes	

Treatment 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
☐ Uplizna Maintenance Dosing	300mg IV every 6 months x 1 year
Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN	

Nursing

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on infusion services, medication administration, self-monitoring and safety

Adverse Event (AE) Protocol

Epinephrine (based on patient weight)
EpiPen® Auto-Injector 0.3mg (1:1000) Inject IM or SubQ to patients who weigh ≥ 30 kg (66 lbs); may repeat in 3-5 minutes x1 if necessary.
EpiPen Jr® Auto-Injector 0.15mg (1:2000) Inject IM or SubQ for patients who weigh 15 - 30 kg (33-66lbs); may repeat in 3-5 minutes x1 if necessary.
Diphenhydramine 50mg (1 mL) If not previously administered, give 50mg slow IVP, or administer IM if no IV access; May repeat x1 after 10 minutes, if necessary.
Solumedrol 125 mg IVP
Sodium Chloride 0.9% 500mL Infuse IV at a rate of 30mL/hr.
Zofran 4mg ODT or IVP for nausea
Pepcid 20mg IV for urticaria/rash
Acetaminophen 325-650 mg PO x1 PRN pain if not already administered OR ibuprofen 200-400mg PO prn pain

Provider Information

By signing this form and utilizing our services, you are authorizing Nira Medical 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.

Office Contact Name:	Email Address:
Prescriber Name:	Date:
Prescriber NPI:	Phone: Fax:
Prescriber Signature:	