SPRINGSIDE INFUSION

Uplizna

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis
☐ Neuromyelitis optica spectrum disorder (g36.0)
☐ Immunoglobulin g4-related disease (lgg4-rd) in adult patients (d89.84)
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications
☐ N/A
☐ Provider prescribed: _____

Medication order

Dose
☐ 300 mg
☐ Other _____

Frequency
☐ Initial: weeks 0 and 2, then every 6 months (starting 6 months from 1st infusion)
☐ Subsequent: every 6 mos
☐ Other _____

Medication route
☐ IV
☐ Other _____

Lab order (Include frequency)
Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

Prerequisites
Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative Hep B | Negative TB

Please send to ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

Referring provider information

Referring provider name _____ **NPI** _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____