UPLIZNA (INEBILIZUMAB) INFUSION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□ lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Medication Orders	Refills
Uplizna (inebilizumab)	☐ Initial dosing: 300mg IV followed by 300mg IV 2 weeks later, then 300mg IV every 6 months (starting 6 months from the first infusion) ☐ 300mg IV every 6 months	☐ x 1 year ☐ _____

Protocol Pre-Medications: Solu-Medrol 125mg IV, diphenhydramine 25mg PO, and acetaminophen 650mg PO to be given 30 minutes prior to infusion (if no contraindications)

Other orders: _____

Lab Orders: _____ Frequency: _____

Required labs to be drawn by □ Infusion Center □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* 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.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR UPLIZNA (INEBILIZUMAB) THERAPY

PATIENT INFORMATION

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

For NMOSD (*required*), please answer:

- 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): _____

For IgG4-RD (*required*), please answer:

- ACR/EULAR IgG4-RD Classification Criteria Score: _____
- Has the patient had a documented contraindication/intolerance or failed trial of rituximab, steroid, or immunosuppressant? □ Yes □ No
  If yes, which drug(s): _____

For gMG (*required*), please answer:

- MG-ADL score: _____
- MGFA clinical classification (I, II, III, IV, V): _____
- Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids, oracetylcholinesterase inhibitors)? ☐ Yes ☐ No If yes, which drug(s)? _____

☐ Include **labs** (i.e.,IgG4) and/or test results to support diagnosis
☐ Other medical necessity: _____
☐ Prescriber-please enroll patient in the manufacturer HUB program

REQUIRED PRE-SCREENING

☐ **TB screening test completed within 12 months**
  ☐ **Positive □ Negative**
☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total(not IgM)**
  ☐ **Positive □ Negative**
☐ **Serumimmunoglobulins**
☐ **AQP4positive antibody lab (NMOSD diagnosis)**
☐ **MuSKor AChR positive antibody lab (gMG diagnosis)**