Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

Uplizna (inebilizumab) Order Form

Epic Referral: REF115248

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:** _____

Rx:

☐ **Induction dosing:** Inebilizumab 300mg IV every 14 days x 2 treatments

☐ **Maintenance Dosing:** Inebilizumab 300 mg every 6 months (beginning 6 months after the 1st dose)

Duration: ☐ 6 months ☐ 1 year ☐ Other: _____

Pre-meds: (given at each inebilizumab infusion)

☐ Solumedrol 100 mg IV or ☐ Solumedrol _____ mg IV

☐ Tylenol 650 mg po or ☐Tylenol _____ mg po

☐ Benadryl ____ mg po or ☐ Benadryl _____ mg IV

☐ Famotidine 20mg po

☐ Other: _____

Solumedrol, Tylenol, and antihistamine recommended per package insert.

Please send Hep B Panel and TB results with order, we cannot infuse without documentation.

Last date and type of TB test: _____ (please fax copy of results with order)

Last date of Hepatitis B panel: _____ (please fax copy of results with order)

Labs:

☐ Draw CBC w/diff and CMP at each inebilizumab infusion

Other labs (include frequency): _____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

**Urine hCG screening will be done prior to each treatment course where applicable

Prescriber Printed Name:_____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____