Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

Office Fax # (_____) _____-_____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Uplizna (inebilizumab) Treatment Plan

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- Myasthenia Gravis without acute exacerbation ICD-10 Code G70.00

☐ Diagnosis- Myasthenia Gravis with acute exacerbation ICD-10 Code G70.01

☐ Diagnosis- IgG4- related disease ICD-10 Code D89.84

☐ Diagnosis- Neuromyelitis Optica ICD-10 Code G36.0

☐ Diagnosis- Other_____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____ ☐ Order Duration: 12 Months ☐ Other_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

☑ Vital Signs (Month 1 to 12) BP/HR/Resp/SpO2/Temp
Baseline on arrival to unit, at each infusion rate change, upon completion of therapy, and prior to discharge

Pre- Treatment Medications

(Manufacturer recommends premedication with corticosteroid, antihistamine and antipyretic)

Acetaminophen (Month 1 to 12)

☑ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before dose

Diphenhydramine (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

Methylprednisolone (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

Uplizna (inebilizumab)

☑ 300 mg, Intravenous, in 250 ml NS to infuse over 90 minutes per step protocol (total volume 280 ml)
Comments: Requires in-line filter 0.2-0.22 micron filter. Do not shake.

Frequency

☐ Induction: Infuse at week 0 and 2

☑ Maintenance: Infuse every 6 months (from week 0)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date _____

uplinza (inebilizumab) Treatment Plan

Nursing Orders:

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

☑ Nursing Order (Month 1 to 12)
Nuse to monitor patient for 1 hour post infusion.

☑ Communication Order
Obtain results of PPD test or other test to exclude latent tuberculosis if results not present in medical record. Results must be from the last 12 months

☑ Communication Order
Obtain results of Hepatitis B lab test or other test to rule out active hepatitis B infection if results not present in medical record. Results must be from the last 12 months

☑ Nursing Order (Month 1 to 12)
Hold Treatment and notify provider for: active infection, antibiotic therapy, antifungal therapy, active fever/infection, planned/recent invasive surgery or procedure, chance of pregnancy, s/s of multifocal leukoencephalopathy.

☑ Notify Provider (Month 1 to 12)
Notify provider for any live/live-attenuated vaccine administration within the last 4 weeks and hold uplinza until provider clearance is received

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130, and hold treatment

Labs (As Needed) Duration: 12 months

☑ QuantiFERON TB Gold Plus (if needed)
☑ Hepatitis B Surface Antibody, Qual-(499) (If needed)
☑ Hepatitis B Surface Antigen w Ref/Conf-(498) (If needed)
☑ Hepatitis B Core Antibody, Total-(501) (If needed)
☑ HCG Pregnancy Screening- Urine (If needed)

Patient Monitoring Acknowledgement:

*CMC Outpatient Infusion Services (OIS) shall ensure negative HCG urine pregnancy screen is completed for females age 11-55 years of age with no history of hysterectomy or bilateral oophorectomy. Referring provider acknowledges that patients who fall into this category for screening have been educated about the reproductive risks associated with inebilizumab infusion, the need for screening prior to each infusion, and have received counseling related to the need for effective contraception during treatment and for a minimum of 6 months following therapy completion.

Provider Initials_____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____ Patient Name _____ Patient DOB_____