UPLIZNA® (inebilizumab-cdon)

Referral Form

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	
ICD-10 code (required):		ICD-10 description:		Last Treatment Date:		Last 4 SSN:	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

Primary Insurance		Name of the Insured		Relationship	
Member ID#		Group #		Insurance Phone #	
Secondary Rx Carrier		Rx ID #		Rx Group #	

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Practice Address:	

NURSING

☐ Infusion to be administered per DeliverIt protocols.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____

DeliverIt Infusion will perform pregnancy screening prior to every infusion per DeliverIt policy

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg PO IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

Other: _____

Dose: _____ Route: _____

UPLIZNA THERAPY ADMINISTRATION

☐ Initial Dosing: 300 mg IV infusion followed two weeks later by a second 300mg IV infusion, then 300 mg every 6 months

☐ Maintenance Dosing (check only if patient is currently on therapy): 300 mg IV infusion every 6 months

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REQUIRED DOCUMENTATION

- ☐ Patient Demographics
- ☐ Insurance Card/Information
- ☐ Progress Notes Supporting DX
- ☐ Current Medication List and H&P
- ☐ Serum Immunoglobulin
- ☐ HepB Core (if available)
- ☐ Hep B Surface Ag (within 36 months)
- ☐ TB results (within 6 months)
- ☐ AQP4

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.
Order is valid for one year unless otherwise noted

Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Date

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Prescriber's Signature

X _____

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance