

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800
Please mark the appropriate infusion center:

- Allenmore Infusion Center
- Auburn Infusion Center
- Gig Harbor Infusion Services
- Puyallup Infusion Center
- DHEC Infusion Center
- North Spokane Infusion Center
- North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Inebilizumab-cdon (Uplizna®)

Patient Name: _____ Requested Date of Service: ____/____/____

Date of Birth: ____/____/____ Patient Phone Number: (____) _____ - _____ May leave message

ICD -10 Code:

Diagnosis: Neuromyelitis optica spectrum disorder _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

****If required documentation not received with order, scheduling of treatment will be delayed until complete information is available****

**** Administer all immunizations according to immunization guidelines at least 4 weeks prior to initiation of Inebilizumab-cdon for live or live attenuated vaccines.**

Baseline labs required:

- Latent TB testing Date ____/____/____ Results: _____
- Hepatitis B screening Date ____/____/____ Results: _____

Maintenance labs required:

- Annual Latent TB testing

IV Access: Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Treatment Regimen:

- Inebilizumab-cdon 300 mg IV in 250 ml NS with an in-line filter every 6 months
Infuse over ~90 minutes at an increasing rate: 42 mL/hour x 30 min, followed by 125 mL/hour for 30 min, then 333 mL/hour until completion.
- Pre-meds give 30 minutes prior to inebilizumab-cdon:
 - Methylprednisolone 125 mg IV x 1 dose
 - Acetaminophen 650 mg po 1 dose
 - Diphenhydramine 25 mg po x 1 dose

Vital Signs: Check vital signs prior to and at completion of infusion.
Contract provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4C)

If hypersensitivity develops (fever, chills, hypertension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: Yes No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature _____ Print Name _____ Date _____ Time _____

Another brand of drug, identical in form and content, may be dispensed unless checked **Order expires in 12 months****

Patient Identification - Always Attach Patient Label

Name: _____
MRN #: _____
CSN #: _____
Age / Sex and Gender: _____

Pre-printed Order
**NEUROMYELITIS OPTICA
SPECTRUM DISORDER**

