

Please fax both pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](http://MyAccredoPatients.com) to log in or get started.

## Prescription & Enrollment Form Uplizna® (inebilizumab injection)

accredo®

Four simple steps to submit your referral.

### 1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient  Current patient

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Male  Female  Last 4 digits of SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

OK to leave message with alternate caregiver/contact

Patient's primary language: English  Other  If other, please specify \_\_\_\_\_

### 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_

Prescriber's title \_\_\_\_\_ If NP or PA, under direction of Dr. \_\_\_\_\_

Office address \_\_\_\_\_

Office contact and title \_\_\_\_\_

Office contact phone number \_\_\_\_\_ Office contact e-mail \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_ Clinic/hospital affiliation \_\_\_\_\_

Street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Infusion clinic contact \_\_\_\_\_ Phone \_\_\_\_\_ E-mail address \_\_\_\_\_

### 3 Clinical Information

Primary ICD-10 code: \_\_\_\_\_ Diagnosis G36.0 Neuromyelitis optica Other \_\_\_\_\_

Is the patient anti-aquaporin-4 antibody positive? Yes  No  Test pending

Prior NSMOD therapies tried/failed \_\_\_\_\_

Hep B vaccination: Yes  No  Date \_\_\_\_\_ Does the patient have active Hepatitis B infection? Yes  No

Hepatitis B screening: Hepatitis B surface antigen (HBsAg) results Positive  Negative  Date \_\_\_\_\_

HB core antibody [HBcAb+] results Positive  Negative  Date \_\_\_\_\_

Does the patient have active or latent TB infection? Yes  No  Tuberculosis screening: Positive  Negative  Date \_\_\_\_\_

FIRST TWO LOADING DOSES COMPLETED Yes  No  **Note: Uplizna loading doses must be administered in a controlled setting.**

EXPECTED DATE OF FIRST/NEXT INFUSION \_\_\_\_\_

NKDA Known drug allergies \_\_\_\_\_

Concurrent meds \_\_\_\_\_

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

# 4 Prescribing Information

**\*Provide address for the selected shipment option.  
Check Unknown if assistance is needed to identify infusion site.**

Medication	Dose	Directions	Quantity/Refills	Ship to*:
Uplizna® (inebilizumab injection) Initial dose (two infusions) <b>Note: Loading doses must be administered in a controlled infusion site.</b>	100mg/10mL SDV Each dose 300mg/30mL diluted in 250mL of 0.9% sodium chloride injection for final concentration of 1.1mg/mL	<b>Infusion 1:</b> 300mg in 250mL of 0.9% NS. <b>Infusion 2</b> (2 weeks later): 300mg in 250mL of 0.9% NS. Start infusion at 42mL per hour for the first 30 minutes, increase to 125mL per hour for the next 30 minutes, then increase to 333mL per hour until finished. Duration: 2 hours or longer Monitor patient for at least one hour after infusion completion for infusion reaction.	Dispense: 6 vials No refills	Office Infusion Clinic Unknown
Uplizna® (inebilizumab injection) Maintenance dose (one infusion)	100mg/10mL SDV Each dose 300mg/30mL diluted in 250mL of 0.9% sodium chloride injection for final concentration of 1.1mg/mL	Every 6 months (from first infusion) infuse 300mg in 250mL of 0.9% NS. Start infusion at 42mL per hour for the first 30 minutes, increase to 125mL per hour for the next 30 minutes, then increase to 333mL per hour until finished. Duration: 2 hours or longer Monitor patient for at least one hour after infusion completion for infusion reaction.	Dispense: 3 vials Refills 0 1	Home Office Infusion Clinic Unknown

All Uplizna® orders to be administered via pump and peripheral line unless otherwise instructed.

### Additional Medication and Supplies for Home Infusion

#### Premedication Orders

Acetaminophen 650mg PO 30 min prior to infusion; Diphenhydramine 50mg PO 30 min prior to infusion; Methylprednisolone 100mg IV 30 min prior to infusion

Other \_\_\_\_\_

Send quantity sufficient for medication infusion  
All caregivers and ancillaries to be given per protocol from product package insert. (See next page).

#### Fluids for Reconstitution and Administration

0.9% NaCl 250mL x2 (initial dose); 0.9% NaCl 250mL (maintenance dose);  
0.9% NaCl Flush 10mL (3 mL pre- and post-infusion to maintain peripheral line patency)  
0.9% NACL 50mL  
0.9% NACL 100mL

If patient requires specific directions on additional medications or supplies, please provide change on the next page and sign.

#### Hypersensitivity/Anaphylaxis Orders\*

In the event of anaphylactic reaction, stop infusion of drug immediately. Start NS 15mL/hour; 0.9%NS 100mL. Medicate with epinephrine pen auto-injector 0.3mg/0.3mL IM as needed for anaphylaxis. Call \*911\*, physician, or paramedic.

I authorize ancillary supplies or medical equipment necessary such as needles, syringes, etc. to administer the therapy as needed for administration.

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.  
\*If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

**Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)**

**SIGN  
HERE**

Date

Dispense as written

Date

Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.



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## Accredo Additional Medications for Home Infusion Protocol as Per Package Insert

If your patient requires individualized dosing or administering, please cross out directions below, provide desired directions in the box and sign.

Date	Signature	
Medication	Dose	Directions
Diphenhydramine	50mg/1mL (25mg)	30 minutes prior to infusion, withdraw 0.5ml and inject into 50mL 0.9% NS. Infuse intravenously 101mL/hour over 30 min.
Diphenhydramine	50mg/1mL (50mg)	30 minutes prior to infusion, withdraw 1mL and inject into 50mL 0.9% NS. Infuse intravenously 102mL/hour over 30 min.
Solu-medrol (Methylprednisolone)	100mg and Benadryl PO	30 min prior to infusion, activate vial, withdraw 1.6mL/100mg, inject into 50mL 0.9% NS. Infuse intravenously 104mL/hour over 30 minutes.
Solu-medrol (Methylprednisolone)	100mg and Benadryl IV SIG	Activate vial, withdraw 1.6mL/100mg. Inject 100mg (1.6mL) intravenous push 0.2mL per minute for 8 minutes may increase to 0.4mL per minute for 4 minutes based on absence of infusion reactions (nausea, vomiting, headache, flushing, vital sign change) 30 minutes prior to Ocrevus.
Solu-medrol (Methylprednisolone)	125mg SIG	30 minutes prior to infusion, activate vial, withdraw 2mL/125mg, inject into 100mL 0.9% NS. Infuse intravenously 204mL/hour over 30 minutes.
Solu-medrol (Methylprednisolone)	250mg SIG	30 minutes prior to infusion, activate vial, withdraw 4mL/250mg, inject into 100mL 0.9% NS. Infuse intravenously 208mL/hour over 30 minutes.
Solu-medrol (Methylprednisolone)	500mg SIG	30 min prior to infusion, activate vial, withdraw 8mL/500mg, inject into 100mL 0.9% NS. Infuse intravenously 216mL/hour over 30 minutes.
Methylprednisolone	125mg vial and Bacteriostatic water	Reconstitute Methylprednisolone 125mg with 2mL of Bacteriostatic water for injection. Withdraw 1.6mL/100mg. a. Inject 100mg (1.6mL) intravenous push 0.2mL per minute for 8 minutes may increase to 0.4mL per minute for 4 minutes based on absence of infusion reactions (nausea, vomiting, headache, flushing, vital sign change) 30 minutes prior to Ocrevus. b. Withdraw 1.6mL and inject into 50mL 0.9% NS. Infuse intravenously 104mL/hour over 30 minutes. 30 minutes prior to Ocrevus.
Famotidine	20mg	30 minutes prior to infusion, withdraw 2mL and inject into 100mL 0.9% NS. Infuse intravenously 204mL/hour over 30 minutes.
Famotidine	10mg	30 minutes prior to infusion, withdraw 1mL and inject into 100mL 0.9% NS. Infuse intravenously 202mL/hour over 30 minutes.