FUSE INFUSION

175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

☐ _____ ok the switch to biosimilar if insurance formulary prefers

Provider Order Form

Date: _____

Inebilizumab-cdon (Uplizna)

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

ICD-10 code (required): ICD -10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

☑ Tuberculosis status and date (list results here & attach clinicals)
_____

☑ Quantitative serum immunoglobulin (list results here & attach clinicals):
_____

☑ Hepatitis B status & date (list results here & attach clinicals):
_____

PREN-MEDICATION ORDERS

☑ acetaminophen (Tylenol) 650mg IV
☑ diphenhydramine 50mg IV
☑ methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS (OPTIONAL)

☐ cetirizine (Zyrtec) 10mg IV
☐ loratadine (Claritin) 10mg IV
☐ famotidine (Pepcid) 20mg IV
Other:_____
Dose:_____ Route: _____
Frequency:_____

LABORATORY ORDERS

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

THERAPY ADMINISTRATION

☑ Inebilizumab-cdon (Uplizna) intravenous infusion
☐ Induction:
- Dose: 300mg in 250ml 0.9% sodium chloride
- Frequency: on Day 1 and Day 15
- Rate: Start at 42ml/hr x30 min, 125ml/hr x 30 min, then
- 333ml/hr for remainder of infusion
- Duration should be approximately 90 minutes
- Administer through an intravenous line containing a sterile,
- low-protein binding 0.2 or 0.22 micron in-line filter.
- After induction, continue with maintenance dosing below

☐ Maintenance:
- Dose: 300mg in 250ml 0.9% sodium chloride
- Frequency: every 6 months from the first infusion
- Rate: Start at 42ml/hr x30 min, 125ml/hr x 30 min, then
- 333ml/hr for remainder of infusion
- Duration should be approximately 90 minutes
- Administer through an intravenous line containing a sterile,
- low-protein binding 0.2 or 0.22 micron in-line filter.

☑ Flush with 0.9% sodium chloride at the completion of infusion
☑ Patient required to stay for 60-min observation post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Hepatitis B virus, quantitative serum immunoglobulins, and tuberculosis screening is required before the first dose. | Prior to every infusion premedicate with a corticosteroid, an antihistamine, and an antipyretic. | Monitor patients closely during and for at least one hour after infusion.

Provider Name (Print) _____ Provider Signature _____ Date _____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____