

UPLIZNA® (inebilizumab-cdon) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status:

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 Code (required):	ICD-10 Description:	Last Treatment Date:
		Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

NURSING

☒ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

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

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo 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

REQUIRED DOCUMENTATION

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

DIAGNOSIS (select one):

Neuromyelitis optica spectrum disorder (ICD-10: G36)

IgG4 related disease (ICD-10: D89.84)

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

Provider Name (Print)

Provider Signature

Date

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	

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