Please fax both pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form
Uplizna® (inebilizumab injection)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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 _____
Sex at birth: ☐ Male ☐ Female Preferred pronouns _____ 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 _____
Office/clinic/institution name _____
Prescriber info: Prescriber's first name _____ Last name _____
Prescriber's title _____ If NP or PA, under direction of Dr. _____
Office phone _____ Fax _____ NPI # _____ License # _____
Office contact and title _____ Office contact e-mail _____
Office street address _____ Suite # _____
City _____ State _____ Zip _____
Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____
Site street address _____ Suite # _____
City _____ State _____ Zip _____
Infusion site contact _____ Phone _____ Fax _____ E-mail _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ **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) **Note: Loading doses must be administered in a controlled infusion site.**	100mg/10mL SDV Each dose 300mg/30mL diluted in 250mL of 0.9% sodium chloride injection for final concentration of 1.1mg/mL	**Infusion 1**: 300mg in 250mL of 0.9% NS. **Infusion 2** (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: 90 minutes 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: 90 minutes 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 _____

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

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.

Send quantity sufficient for medication infusion

All caregivers and ancillaries to be given per protocol from product package insert. (See next page).

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

☐ 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.

accredo®

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.
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.
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 Uplizna.
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.
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.
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 Uplizna. b. Withdraw 1.6mL and inject into 50mL 0.9% NS. Infuse intravenously 104mL/hour over 30 minutes. 30 minutes prior to Uplizna.
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.

accredo®