# Uplizna Infusion Order

LivWell INFUSIONS

*Fax 888 511-7654* *Phone 888 864-7341*

**Patient Name:** _____ **DOB:** _____

**Patient Phone:** _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

## MEDICAL INFORMATION

**Diagnosis:**

◯ G36.0 Neuromyelitis Optica

◯ D89.84 Immunoglobulin G4-related disease (IgG4-RD)

◯ Other: _____

**ICD-10:** _____

Patients weight: _____

Lab Date: _____

Allergies: _____

**ALSO INCLUDE...**

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

## UPLIZNA ORDER

**Uplizna Dose:**

◯ 300 mg IV infusion Day 1 and 2 weeks later

◯ 300mg IV infusion every 6 months

**Patients weight (kg):** _____

**Premedications:**

Acetaminophen (PO) ◯ 500mg ◯ 650mg ◯ 1000mg

Cetirizine (PO) ◯ 10mg

Loratadine (PO) ◯ 10mg

Diphenhydramine ◯ 25mg ◯ 50mg ◯ PO ◯ IV

Methylprednisolone (IV) ◯ 40mg ◯ 125mg

Hydrocortisone (IV) ◯ 100mg

**Additional Comments:**

## PHYSICIAN INFORMATION

**Referring Physician:** _____ **Phone:** _____

**Practice Address:** _____

**Office Contact:** _____ **Fax:** _____

**NPI/ TIN:** _____

**Referring Physician's Signature**_____ **Date:** _____