



Fax Referrals To: (855) 891-2191
 Email Referrals To: referrals@vivoinfusion.com Have
 a Question? (855) 478-1528

UPLIZNA® (inebilizumab-cdon) ORDER FORM
 (* - Required Fields)

STAT REQUEST
 (*REASON MUST BE PROVIDED BELOW)

New Referral	Referral Renewal	Medication/Treatment Change
Benefits Verification Only		Discontinuation Order

PATIENT INFORMATION

NAME*:		DOB*:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS:		PHONE:	
WEIGHT:	LBS	KG	HEIGHT:
ALLERGIES:		EMAIL:	

PHYSICIAN INFORMATION

PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

UPLIZNA Infusion*:
 (SELECT ONE OF THE FOLLOWING)

Initial dose: 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

ICD-10*: _____

Physician Signature* _____ Date*(Referral Valid for One Year) _____

*NPI # _____ Infusion will be administered per MPP policy and protocols

ICD-10 Description:	REQUIRED DOCUMENTATION CHECKLIST:
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<p>*STAT REASON: (STAT requests will be assessed per MPP policy and protocols)</p> <p>Last Infusion/Injection Date: _____</p>	<p>Patient Demographics</p> <p>Insurance Card/Information</p> <p>Progress Notes supporting DX</p> <p>Current Medication List and H&P</p> <p>Complete Metabolic Panel</p> <p>Hep B Core (if available)</p> <p>Hep B Surface Antigen (within 36 months)</p> <p>TB Results (within 6 months)</p> <p>AQP4</p> <p>Serum Immunoglobulin</p>
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STANDING LAB REQUEST (to be drawn by clinic):	CMP	CBC *Frequency: _____
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Additional comments/notes:

Locations:

-----Colorado-----

Lakewood

-----Florida-----

Jacksonville
 Kissimmee
 Port St. Lucie
 Suncoast
 Winter Park

-----Ohio-----

Beachwood
 Middleburg Hts.
 Painesville
 Youngstown
 Westlake
 Fairlawn

-----Oklahoma-----

Tulsa

-----Texas-----

Arlington
 Cedar Hill
 Dallas
 Denton
 Ft. Worth
 Irving
 Rockwall
 Southlake
 Flower Mound
 Plano
 Tyler