Hy-Vee health INFUSION CARE

UPLIZNA
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

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

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: ☐ Neuromyelitis optica spectrum disorder (ICD-10 Code: G36)

☐ Other: _____ (ICD-10 Code: _____)

Patient weight: _____ lbs. **Allergies:** _____

Therapy Order

Uplizna

☐ Initial dosing: 300 mg IV followed by 300 mg IV 2 weeks later, then 300 mg IV every 6 months (starting 6 months from the first infusion) x1 year

☐ 300 mg IV every 6 months x1 year

Protocol premedication orders: Solu-Medrol 125 mg IV, Benadryl 25 mg PO and Tylenol 650 mg PO to be given 30 minutes prior to infusion (if no contraindications)

Other orders: _____

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Anaphylactic reaction orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg PO or IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

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COMPREHENSIVE SUPPORT FOR UPLIZNA THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of Rituximab, Azathioprine or Mycophenolate Mofetil?
    - ☐ Yes ☐ No
  - ☐ Does the patient have a history of at least 1 relapse (acute attack from neuromyelitis spectrum disorder) in the last 12 months, or 2 relapses in the last 2 years?
    - ☐ Yes ☐ No
  - ☐ Expanded Disability Status Score (EDSS): _____
- ☐ Include labs and/or test results to support diagnosis
- ☐ Other medical necessity: _____

Required Prescreening

- ☐ **TB screening test completed within 12 months – attach results**
  - ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) – attach results**
  - ☐ **Positive** ☐ **Negative**
- ☐ **Serum immunoglobulins – attach results**
- ☐ **AQP4 positive antibody lab – attach results**

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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