Uplizna

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS
smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** Demographics and insurance. Relevant, recent office notes including tried and failed meds. Current medication list
Current Labs: TB, Hep B, CBC with diff, IgG, AQP4 antibody

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: ☐ G36.0 NMOSD

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

TB Test Date: Result: Hep B Date: Result:

PREMEDS

(30 minutes before infusion)

Solu-Medrol:		☐ IV	☐ 125mg	OR	Dexamethasone ☐ IV	☐ 10mg
Diphenhydramine:	☐ PO	☐ IV	☐ 25mg	☐ 50mg		
Acetaminophen:	☐ PO		☐ 500mg	☐ 650mg		

UPLIZNA (INEBILIZUMAB-CDON) DOSAGE:

Date of Last Treatment, If Continuation:

UPLIZNA IV LOADING DOSAGE

☐ **300 mg**
on day 1 and day 15

UPLIZNA IV MAINTENANCE DOSAGE

☐ **300 mg**
6 months after first dose,
then every 6 months