



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION
<input type="checkbox"/> G36.0 Neuromyelitis optica <input type="checkbox"/> Other ICD-10/Diagnosis: _____ Hepatitis B vaccination: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____ - ____ - ____ Hepatitis B screening: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: ____ - ____ - ____ <input type="checkbox"/> HB core antibody HBcAb+ results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: ____ - ____ - ____ Does the patient have active or latent TB infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis screening: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: ____ - ____ - ____ First two loading doses completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Note: Uplizna loading doses must be administered in a controlled setting.

UPLIZNA® ORDERS
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose	Directions	Refills
<input type="checkbox"/> Uplizna® (inebilizumab injection)	<input type="checkbox"/> 100mg/10mL SDV <input type="checkbox"/> Other: _____	<input type="checkbox"/> Initial Dose: <input type="checkbox"/> Infusion 1: 300mg in 250mL of 0.9% NS. <input type="checkbox"/> Infusion 2: (2 weeks later): 300mg in 250mL of 0.9% NS. <input type="checkbox"/> Other: _____ <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Every 6 months (from first infusion) infuse 300mg in 250mL of 0.9% N <input type="checkbox"/> Other: _____	_____
Pre-medication	Dose/Frequency		Refills
IV Corticosteroids	<input type="checkbox"/> 40mg IV Methylprednisolone <input type="checkbox"/> 80mg IV Methylprednisolone <input type="checkbox"/> Other: _____	<input type="checkbox"/> Prior to each infusion <input type="checkbox"/> Other: _____	_____
Oral Antihistamines	<input type="checkbox"/> 60 mg fexofenadine <input type="checkbox"/> 50 mg diphenhydramine <input type="checkbox"/> Other: _____	<input type="checkbox"/> Night before infusion, and/or can administer concomitantly with infusion <input type="checkbox"/> Other: _____	_____
Oral Antipyretic	<input type="checkbox"/> 500 mg acetaminophen <input type="checkbox"/> Other: _____	<input type="checkbox"/> Prior to each infusion <input type="checkbox"/> Other: _____	_____
Anaphylaxis	Dose/Strength	Directions	Refills

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<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 50mg IV <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer over at least 2 minutes as needed for mild to moderate infusion reaction <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Solu-Medrol	<input type="checkbox"/> 125 mg IV <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer over 3-5 minutes as needed for moderate to severe infusion reaction <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> 0.3mg (0.3ml) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer 0.3 mg by intramuscular injection as needed for signs/symptoms of anaphylaxis. May repeat dose after 5-10 minutes if necessary <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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