CURBSIDE INFUSION SERVICES

Patient Name:

DOB:

UPLIZNA® (INEBILIZUMAB-CDON) ORDER SET

Diagnosis:

☑ G36.0 Neuromyelitis Optica Spectrum Disorder _____ (ICD-10) Other: _____.

Prescriber must indicate all of the following requirements have been met (attach supporting documentation):

☐ quantitative immunoglobulins **within normal limits**

☐ anti-aquaporin-4 (AQP4) antibody **positive** ***(required)***

☐ Latent TB screening **negative**

☐ HBV screening **negative**

If any the above are *not* checked, attach treatment/consultation notes clearing patient for inebilizumab-cdon therapy

Pre-Infusion:

☑ **Assess for contraindications; hold infusion and notify provider for**:

- signs/symptoms of active infection;
- planned or recent invasive/surgical procedure;
- receipt of live or live-attenuated vaccines within 4 weeks;
- chance of pregnancy; or
- signs/symptoms of PML (new or worsening unilateral weakness, confusion or changes in vision, thinking, memory, balance, or personality/mood).

☑ **Obtain vital signs at baseline and with rate changes**

☑ **Establish vascular access**

☑ **If infusion-related reaction occurs, stop infusion and treat per orders/protocol as clinically indicated.**

Pre-medications: (Prescriber must select *one* option within each set of brackets for each medication):

☐ acetaminophen **[☐ 500 mg ☐ 650 mg]** ☐ PO once **[☐ 30 ☐ 60]** min prior to infusion

☐ methylprednisolone **[☐ 80 mg ☐ 125 mg ☐ _____ mg]** ☐ IV once **[☐ 30 ☐ 60]** min prior to infusion

☐ diphenhydramine **[☐ 25 mg ☐ 50 mg ☐ _____ mg]** **[☐ IV ☐ PO]** once **[☐ 30 ☐ 60]** min prior to infusion

Medication Orders:

☑ Dilute **inebilizumab-cdon 300 mg/30 mL in 250 mL 0.9% sodium chloride** and administer intravenously using a sterile, in-line, low protein-binding **0.2- or 0.22-micron filter** using rates in table at right.

Elapsed Time (minutes)	Infusion Rate
0-30	42 mL/hr
31-60	125 mL/hr
61 to completion	333 mL/hr

Post-Infusion:

☑ Flush administration set with 0.9% sodium chloride to deliver residual volume.

☑ Record vital signs immediately following infusion and prior to discharge.

☑ Leave IV in place for observation period; remove prior to discharge.

☑ **Monitor patient for hypersensitivity reaction for a period of 60 minutes following infusion.**

☑ Provide patient with discharge instructions.

☑ Send record of treatment to prescriber at fax number below.

☑ Follow standing anaphylaxis order and notify MD of outcome.

Frequency:

☐ On Day 1 and Day 15; repeat in 6 months (from Day 1)

☐ Every 6 months (date of last treatment:_____)

Additional Orders:

Prescriber Name (print): _____ **Fax**: _____.

Prescriber signature: _____ **Date**: _____.

Fax Order To: 281-406-1047 Office: 281-406-1046

Order valid for one year unless otherwise indicated.