WEST TEXAS DIGESTIVE DISEASE CENTER

Houssam Al Kharrat
Gastroenterology
5115 80th Street
Lubbock, TX 79424
Phone: (806) 788-4368
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South Plains Infusion

UPLIZNA (inebilizumab-cdon)

Name:_____ DOB:_____ M ○ F ○ PATIENT WEIGHT

_____lbs

Phone #1 :_____(H/W/C) Phone #2:_____(H/W/C) _____kg

Allergies:_____

DIAGNOSIS:

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

○Other: _____ (ICD-10 Code: _____)

PRE-MEDICATION ORDERS

○Tylenol 500-1000mg PO PRN ○Benadryl 25mg PO PRN

○Solu-Cortef _____ mg SIVP

UPLIZNA ORDER:

○Initial dosing: 300mg IV followed by 300mg IV 2 weeks later, then 300mg IV every 6 months (starting 6 months from the first infusion) x 1 year

○300mg IV every 6 months x 1 year

NOTES:

ORDERING PROVIDER

Signature X_____ Date_____

Provider _____ Phone _____ Fax_____

Please FAX: ○Medication Order ○Demographics ○Clinicals ○Labs ○X-Rays
to 1-806-302-1241 (must dial "1")