TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

UPLIZNA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ______________________ DOB: __________
Address: ______________________________
City, State, Zip: ___________________________
Phone: ______________ Alt. Phone: ______________
Email: __________________ SS#: ______________
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: __________
Allergies: ______________________________

PRESCRIBER INFORMATION

Prescriber Name: ___________________________
State License: _____________________________
NPI #: ____________ Tax ID: ____________________
Address: __________________________________
City, State, Zip: ____________________________
Phone: _______________ Fax: _________________
Office Contact: _______________ Phone: __________

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ___________________________
Plan #: ___________________________
Group #: ___________________________
RX Card (PBM): ___________________________
BIN: ______________ PCN: ______________

Secondary Insurance (If Applicable): ___________________
Plan #: ___________________________
Group #: ___________________________
RX Card (PBM): ___________________________
BIN: ______________ PCN: ______________

CLINICAL INFORMATION

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

UPLIZNA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _________ Date of Last Injection/Infusion: _________

Medication	Dose	Directions	Refills
☐ Uplizna® (inebilizumab injection)	☐ 100mg/10mL SDV ☐ Other: ________	☐ Initial Dose: ☐ Infusion 1: 300mg in 250mL of 0.9% NS. ☐ Infusion 2: (2 weeks later): 300mg in 250mL of 0.9% NS. ☐ Other: ______________________ ☐ Maintenance Dose: ☐ Every 6 months (from first infusion) infuse 300mg in 250mL of 0.9% N ☐ Other: ______________________	__________
Anaphylaxis	**Dose/Strength**	**Directions**	**Refills**
☐ Diphenhydramine	☐ 50mg IV ☐ Other: ______	☐ Administer over at least 2 minutes as needed for mild to moderate infusion reaction ☐ Other:______________________	__________
☐ Solu-Medrol	☐ 125 mg IV ☐ Other: ______	☐ Administer over 3-5 minutes as needed for moderate to severe infusion reaction ☐ Other: ______________________	__________
☐ Epinephrine	☐ 0.3mg (0.3ml) ☐ Other: ______	☐ Administer 0.3 mg by intramuscular injection as needed for signs/symptoms of anaphylaxis. May repeat dose after 5-10 minutes if necessary ☐ Other: ______________________	__________
☐ Other: _________	__________	______________________	__________

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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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