DURANGO INFUSION

INFUSION SUITE		UPLIZNA INFUSION ORDERS	
Durango Infusion Center		**Phone: 970-828-3500**	**Fax: 970-828-3501**
270 E 8th Ave Ste N101 Durango, CO 81301			
PATIENT INFORMATION - Include Patient Demographics and Insurance Cards			
Name:		**DOB:**	
	MEDICAL INFORMATION		
ICD10:		**Patient Height:**	
Patient Weight (kg):		**Allergies:**	
*Weigh patient prior to each infusion			
	REQUIRED TESTING		
☐ **Hepatitis B Panel:**____________	☐ **TB:**_____________	☐ **Serum Immunoglobulins:**_______________	
☐ **Anti-AQP4 antibody:**___________			
Additional labs:			
☐ **Insert IV**	☐ **Access Port/PICC**		
	PREMEDICATIONS 30 minutes prior to starting		
☐ **Acetaminophen:**	☐ 325mg PO X1	☐ 500mg PO X1	☐ 650mg PO X1 ☐ 1000mg PO X1
☐ **Diphenhydramine:**	☐ 25mg IV X1	☐ 25mg PO X1	☐ 50mg IV X1 ☐ 50mg PO X1
☐ **Solumedrol:**	☐ 40mg IV X1	☐ 100mg IV X1	☐ 125mg IV X1
☐ **Antihistamine:**	☐ Cetirizine 10mg PO X1	☐ Loratadine 10mg PO X1	
☐ **Additional PRN:**			
	UPLIZNA ORDERS		
☐ Initial:	Uplizna 300mg IV in 250mL NS over 90 minutes on day 0 and day 15		
☐ Maintenance:	Uplizna 300mg IV in 250mL NS over 90 minutes every 6 months X __________		
	POST INFUSION		
☐ Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
☐ Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
☐ Discharge after 1 hour observation time			
☐ Discharge home without observation time			
Referring Provider Printed:			
Referring Provider Signature:		**Date:**	
Referring Provider Phone:		**Referring Provider Fax:**	
DNG Provider Printed:			
DNG Provider Signature:		**Date:**	

Credentials must be included

Infusion Directions:

- Draw up 30mL Uplizna (and transfer into 250mL NS bag, do not remove any NS volume
- Infuse through a low protein binding 0.2 or 0.22 micron in-line filter tubing over 90 minutes
- Monitor/Observe patient for 60 minutes post infusion

Time	Pump Rate
0-30 minutes	42 mL/hour
31-60 minutes	125 mL/hour
61 minutes until completion	333 mL/hour