

INFUSION SUITE		UPLIZNA INFUSION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
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			
<input type="checkbox"/> Hepatitis B Panel: _____ <input type="checkbox"/> TB: _____ <input type="checkbox"/> Serum Immunoglobulins: _____			
<input type="checkbox"/> Anti-AQP4 antibody: _____			
Additional labs: _____			
<input type="checkbox"/> Insert IV	<input type="checkbox"/> Access Port/PICC		
PREMEDICATIONS 30 minutes prior to starting			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Methylprednisolone:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1 <input type="checkbox"/> Loratadine 10mg PO X1		
<input type="checkbox"/> Additional PRN:	_____		
UPLIZNA ORDERS			
<input type="checkbox"/> Initial:	Uplizna 300mg IV in 250mL NS over 90 minutes on day 0 and day 15		
<input type="checkbox"/> Maintenance:	Uplizna 300mg IV in 250mL NS over 90 minutes every 6 months X _____		
POST INFUSION			
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
<input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
<input type="checkbox"/> Discharge after 1 hour observation time			
<input type="checkbox"/> Discharge home without observation time			
Referring Provider Printed:		NPI:	
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