Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Inebilizumab-cdon (UPLIZNA) Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Treatment Start Date: _____ Allergies: _____

Weight: _____kg Height: _____cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

1. **FACE SHEET with complete INSURANCE information and patient CONTACT information**
2. **Recent VISIT NOTE to support treatment (if not available in Epic)**
3. **LAB RESULTS for any required prescreening (if not available in Epic)**
4. **DIAGNOSIS CODE _____**
5. **Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Hepatitis B surface antigen and core antibody test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- ☐ IGG, Serum, Routine, ONCE, every (visit)(days)(weeks)(months) – Circle One
- ☐ IGM, Serum, Routine, ONCE, every (visit)(days)(weeks)(months) – Circle One

NURSING ORDERS:

1. TREATMENT PARAMETER - Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. VITAL SIGNS - Obtain vital signs at baseline, then every 15 minutes for the first hour, then every 30 minutes.
3. ASSESS TEMPERATURE - Temp every hour during inebilizumab-cdon (UPLIZNA) infusion.
4. Infuse 42 mL/hr (0-30 minutes), then increase rate to 125 mL/hr (31-60 minutes), then 333 mL/hr (61 minutes to completion).
5. HYPERSENSITIVITY/INFUSION REACTION - Monitor patient for infusion related reaction for 1 hour after completion of the infusion.
6. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☑ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☑ diphenhydrAMINE (BENADRYL) capsule or tablet, 50 mg, oral, ONCE, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- ☑ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- ☑ methylPREDNISolone sodium succinate (SOLU-MEDROL), 125 mg, intravenous, ONCE, every visit

MEDICATIONS:

- ineblizumab-cdon (UPLIZNA) in 250 mL sodium chloride 0.9% IV, intravenous, administer over 90 minutes. Administer through IV line containing low protein binding 0.2 or 0.22 micron in-line filter.

  Initial Doses:
  Interval: (must check one)
  - ☐ 300 mg once, then 300 mg two weeks later

  Maintenance Doses:
  Interval: (must check one)
  - ☐ 300 mg once every 6 months (24 weeks)

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ **License #:** _____ **Date:** _____

Print Name: _____ **Phone:** _____ **Fax**:_____

Plan will expire 1 year after signature date at which time a new order will need to be placed

OHSU Infusion Locations

Contact the Referral Team directly for assistance at the centralized numbers below (do not contact individual clinics

INFUSION REFERRAL TEAM

Fax completed orders to (503) 346-8058
Phone (providers only) (971) 262-9645

Infusion orders located at: www.ohsuknight.com/infusionorders

☑ **Please indicate the patient's preferred clinic location below**	
☐ **BEAVERTON** OHSU Knight Cancer Institute	15700 SW Greystone Court Beaverton OR 97006
☐ **NW PORTLAND** Legacy Good Samaritan campus	Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210
☐ **GRESHAM** Legacy Mount Hood campus	Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030
☐ **TUALATIN** Legacy Meridian Park campus	Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062
☐ **Community providers only (no Legacy)** **EAST PORTLAND** Adventist Health Portland campus	Pavilion – 10000 SE Main St – Suite 350 Portland, Oregon 97216

Referral team will consider other locations as appropriate (e.g. selected site not available, urgent treatment, patient preference)

OHSU Partner Infusion Locations

☑ **Please indicate the patient's preferred clinic location below**
Not all therapies are offered at every site, contact site for more information

☐ **Community providers only (no Legacy)** **HILLSBORO MEDICAL CENTER** **Fax completed orders to (503) 681-4120**	364 SE 8th Ave – Medical Plaza Suite 108B Hillsboro, OR 97123 Phone (providers only) (503) 681-4124
☐ **Community providers only (no Legacy)** **ADVENTIST HEALTH – PORTLAND** **Fax completed orders to (503) 261-6756**	Infusion Services – 10123 SE Market St Portland, OR 97216 Phone (providers only) (503) 261-6631