LivWell INFUSIONS

Uplizna Infusion Order

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

◯ G36.0 Neuromyelitis Optica

◯ Other: _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD-10: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

UPLIZNA ORDER

Uplizna Dose:

◯ 300 mg IV infusion Day 1 and 2 weeks later

◯ 300mg IV infusion every 6 months

Patients weight (kg): _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____