406 ARTHRITIS CLINIC
Get back to your 406 life!

INFUSION SUITE		UPLIZNA INFUSION ORDERS	
406 Arthritis Clinic LLC		Phone: 406-345-0211	Fax: 747-205-0742
2409 Arnold Ln Ste 9 Billings, MT 59102			
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		
☐ **Diphenhydramine:**	☐ 25mg IVP X1 ☐ 25mg PO X1 ☐ 50mg IVP 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 NS. D/C IV.			
☐ Flush port with 5-10mL 0.9% NS. Lock port with Heparin 10u/mL IVP (based of size port). De-access port.			
☐ Discharge after 1 hour observation time			
☐ Discharge home without observation time			
Referring Provider Printed:			
Referring Provider Signature:		**Date:**	
Referring Provider Phone:		**Referring Provider Fax:**	
406 Provider Printed:			
406 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