arise infusion
THERAPY SERVICES
A DIVISION OF ARTHRITIS AND RHEUMATISM ASSOCIATES, PC

Fax To: 301-424-3590
Have a Question? Call: 240-514-5000

UPLIZNA (inebilizumab-cdon) ORDER FORM

REFERRAL TYPE

☐ New Referral ☐ Order Renewal ☐ Restart ☐ Frequency Change ☐ Dosage Change

PREFERRED LOCATION

☐ 2730 University Blvd. West | Suite 714 Wheaton, MD 20902	☐ 14995 Shady Grove Road | Suite 250 Rockville, MD 20850	☐ 5454 Wisconsin Avenue | Suite 600 Chevy Chase, MD 20815
☐ 18111 Prince Philip Drive | Suite 323 Olney, MD 20832	☐ 71 Thomas Johnson Drive Frederick, MD 21702	☐ 2021 K Street, NW | Suite 300 Washington, DC 20006
	☐ 8270 Willow Oaks Corporate Drive | Suite 150 Fairfax, VA 22031	

PATIENT INFORMATION

Name:	DOB:	Email:
Address:	Weight: KG LBS	Phone:

REFERRING PHYSICIAN INFORMATION

Name:		NPI:
Office Contact Name:	Phone:	Fax:
Address:		

OCREVUS ORDER

OFF-LABEL diagnosis, dose and frequency are subject to medical review and approval.

Dosing/Frequency:

☐ Initial Dose: 300mg IV at 0 and 2 weeks, then 300mg IV every 6 months

☐ Maintenance Dose: 300mg IV every 6 months

Diagnosis:

☐ G36.0—Neuromyelitis Optica (Devic)

☐ Other Diagnosis: ICD-10 Code (Required):

Ambulate: ☐Independent ☐With Assistance ☐Wheelchair ☐Stretcher

Special Instructions:

Physicians Signature:	Date: ***(Order is Valid for One Year)***

REQUIRED DOCUMENTATION

Please fax the following documents and records:

- Patient Demographics
- Three most recent office notes (Supporting the DX and treatment ordered
- Most recent labs that include values for:
  - CMP, CBC, HBV Surface Antigen, Quantitative Serum Immunoglubulins, TB Screening (PPD, QFT gold, T-Spot)
- Copy of the patient's insurance card(s) – front and back
- Medication History
- For continuation of treatment, include the last infusion note
- Statement of Medical Necessity (SMN) form supplied by

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.