ADVANCED
INFUSION CENTER

Uplizna Infusion Order

Patient Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs/kg

Diagnosis: _____ ICD 10: _____

Uplizna Order: circle all that applies

- **Initial dose: On day 1 and day 15; repeat in 6 months (from day 1)**
- **Subsequent doses: Every 6 months (date of last treatment): _____**

Infusion rate for Uplizna When Diluted in 250 ml of 0.9% Normal Saline: 90 min. infusion

- **42ml/hr. x 30 minutes (21ml)**
- **125ml/hr. x 30 minutes (62.5ml)**
- **333ml/hr. to completion (166.5ml)**

Recommended pre-medications: check all that apply; administer 30 min. prior

- **Solu-Medrol _____ mg IV x1**
- **Diphenhydramine _____mg or po x1**
- **Acetaminophen _____ mg po x1**

For Infusion related Reactions: Use AIC reaction Protocol and notify physician

Physician signature: _____ Date: _____

Physician name (printed): _____

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