Neurology Order Form

Fax completed form to: 833-908-1122

PATIENT INFORMATION

Patient Name:	Date of Birth:	Referral Date:
Address:		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	Male Female
Patient Diagnosis & ICD-10:		
Allergies:		

PROVIDER INFORMATION

Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH

- Patient demographics & front/back copy of all insurance cards (prescription & medical)
- Recent office visit notes, history & physical, lab & pertinent procedure results
- Current medication list & list of prior medications tried and failed (with dates)
- Line access documentation/verification if applicable
- Quantitative serum Immunoglobulin lab results *(Uplizna only)*
- TB lab results within last 12 months *(Uplizna only)*
- Vaccine status (any vaccination) and documentation of any recent vaccinations
- HBV lab results within last 12 months (*Uplizna only*)
- Date of diagnosis, current FVC%, ALSFRS-R score, and JourneyMate form *(Radicava only)*
- Anti-acetylcholine receptor (AChR) antibody positive results *(Vyvgart)*
- Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.
Flush Orders: *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed *Heparin -* 10units/mL ***---OR---*** 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line
Lab Orders: **Lab Date & Frequency:**

PRESCRIPTION ORDERS

Anaphylaxis Kit: (Check all that apply)	Epinephrine 0.3mg IM as needed Diphenhydramine ________ mg IV as needed	Solu-cortef 250mg-500mg IV as needed NS Hydration 500 ml IV over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV as needed Other
Pre-Medications: (Check all that apply)	Acetaminophen ________mg PO ________ minutes prior to infusion Diphenhydramine ________ mg PO ***---OR---*** IV _____minutes prior to infusion	Solu-Medrol ______mg IV ___minutes prior to infusion	Other

Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
	Is this a first dose? Yes No If No, when was last dose given?__________________ When is patient due for next dose?__________________	
RADICAVA	**Induction**: 60mg IV infusion via gravity ***---OR---*** pump over 1 hour daily for 14 days followed by 14 day drug-free period	NONE
	Maintenance: 60mg IV infusion via gravity ***---OR---*** pump over 1 hour daily for 10 days out of 14 day period followed by 14 day drug-free periods	________
UPLIZNA	**Induction**: 300mg IV infusion via gravity ***---OR---*** pump over approximately 90 minutes at 0 and 2 weeks and *CBC lab testing every _____ months*	NONE
	Maintenance: *(starting 6 months from first infusion)* 300mg IV infusion via gravity ***---OR---*** pump over approximately 90 minutes every 6 months	________
VYEPTI	100mg IV infusion via gravity ***---OR---*** pump over approximately 30 minutes every 12 weeks 300mg IV infusion via gravity ***---OR---*** pump over approximately 30 minutes every 12 weeks	________
VYVGART	10mg/kg IV infusion via gravity ***---OR--- ---OR---*** pump over at least 1 hour once every week for 4 weeks **Up to max of 1200mg for patient weight of 120kg+ (Total volume is 125ml in NS solution)* Administer additional treatment cycles every 50 days ***---OR---*** Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle According to the Package Insert: Administer subsequent treatment cycles based on clinical evaluation; the safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.	________
VYVGART HYTRULO	1,008mg/11,200 units subcutaneous injection over approximately 30 to 90 seconds in cycles of once weekly injections for 4 weeks Administer additional treatment cycles every 50 days ***---OR---*** Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle According to the Package Insert: Administer subsequent treatment cycles based on clinical evaluation; the safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.	________
IG	***Refer to Immunoglobulin Form***	
SOLIRIS/ULTOMIRIS	***Refer to Soliris or Ultomiris Order Form***	
OTHER		NONE ________

By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature **<u>Dispense as Written</u>**	**Print Name**	**Date**	**Prescriber's Signature** **<u>Substitution Permitted</u>**	**Print Name**	**Date**

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