

Neurology Order Form



Fax completed form to: _____

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 (<i>Uplizna only</i>) TB lab results within last 12 months (<i>Uplizna only</i>)		Vaccine status (any vaccination) and documentation of any recent vaccinations HBV lab results within last 12 months (<i>Uplizna only</i>) Date of diagnosis, current FVC%, ALSFRS-R score, and JourneyMate form (<i>Radicava only</i>) Anti-acetylcholine receptor (AChR) antibody positive results (<i>Vyvgart</i>) 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 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		NONE
UPLIZNA	Induction: 300mg IV infusion via gravity ---OR--- pump over approximately 90 minutes at 0 and 2 weeks and CBC lab testing every _____ months Maintenance: (starting 6 months from first infusion) 300mg IV infusion via gravity ---OR--- pump over approximately 90 minutes every 6 months		NONE
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--- 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)		_____
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, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature _____
 Dispense as Written _____
 Print Name _____
 Date _____

Prescriber's Signature _____
 Substitution Permitted _____
 Print Name _____
 Date _____