

# 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			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> 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 <b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>			
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> (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 _____
<b>Pre-Medications:</b> (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 _____
<b>Supply Orders:</b> 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	<b>Induction:</b> 60mg IV infusion via gravity ---OR--- pump over 1 hour daily for 14 days followed by 14 day drug-free period <b>Maintenance:</b> 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	<b>Induction:</b> 300mg IV infusion via gravity ---OR--- pump over approximately 90 minutes at 0 and 2 weeks and CBC lab testing every _____ months <b>Maintenance:</b> (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--- ---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	<b>Refer to Immunoglobulin Form</b>		
SOLIRIS/ULTOMIRIS	<b>Refer to Soliris or Ultomiris Order Form</b>		
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  
Dispense as Written

Print Name

Date

Prescriber's Signature  
Substitution Permitted

Print Name

Date