# Neurology Order Form

**Fax Completed Form To:** **Phone:**

amerita specialty infusion services | Ivy Specialty Infusion an amerita company

## 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 ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed
☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other

**Pre-Medications:** (Check all that apply)
☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV ____ minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ 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?_____ | |
| ☐ KISUNLA | ☐ **Induction**: 700mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over 30 minutes every 4 weeks x 3 doses | NONE |
| | ☐ **Maintenance**: 1400mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over 30 minutes every 4 weeks | _____ |
| | ☐ If missed dose, administer the same dose as soon as possible and continue every 4 weeks | |
| ☐ 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<br>☐ 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<br>**Up to max of 1200mg for patient weight of 120kg+ (Total volume is 125ml in NS solution)*<br>Administer additional treatment cycles ☐ every 50 days ***---OR---*** ☐ Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle<br>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<br>Administer additional treatment cycles ☐ every 50 days ***---OR---*** ☐ Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle<br>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 assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.***

**Prescriber's Signature** **Print Name** **Date**

**Prescriber's Signature** **Print Name** **Date**




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**THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.**

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