Neurology Order Form





Fax completed form to: 833-908-1122

2.4	PATIENT INFORMATION	
Patient Name:	Date of Birth: Referral Date:	
Address: Home Phone:	City/State/Zip: Cell Phone: Work Phone:	
Secondary Contact:	Height: Weight: Wale Female	
Patient Diagnosis & ICD-1		
Allergies:		
PROVIDER INFORMATION		
Physician Name:	Lic.#: DEA #:	
Practice Name:	NPI#:	
Address:	City/State/Zip:	
Office Contact:	Phone: Fax:	1
Supervisory Physician (if a		
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/mLOR 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 Diphenhydraminemg IV as needed NS Hydration 500 ml IV over 30 minutes as needed Other	s needed
Pre-Medications:	Acetaminophenmg POminutes prior to infusion Solu-Medrolmg IVminutes prior to infusion	
(Check all that apply)	Diphenhydramine mg PO OR IVminutes 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? Ye	es No If No, when was last dose given?When is patient due for next dose?	
RADICAVA	Induction: 60mg IV infusion via gravityOR 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 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 day from the start of the previous treatment cycle has not been established.	s ——
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 day from the start of the previous treatment cycle has not been established.	s
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>

Prescriber's Signature Substitution Permitted Print Name

Date





Print Name

Date