

Neurology Order Form

Fax Completed Form To:

Phone:



PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	<input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical)	<input type="checkbox"/> Vaccine status (any vaccination) and documentation of any recent vaccinations
<input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results	<input type="checkbox"/> HBV lab results within last 12 months (<i>Uplizna only</i>)
<input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates)	<input type="checkbox"/> Date of diagnosis, current FVC%, ALSFRS-R score, and JourneyMate form (<i>Radicava only</i>)
<input type="checkbox"/> Line access documentation/verification if applicable	<input type="checkbox"/> Anti-acetylcholine receptor (AChR) antibody positive results (<i>Vyvgart</i>)
<input type="checkbox"/> Quantitative serum Immunoglobulin lab results (<i>Uplizna only</i>)	<input type="checkbox"/> Letter of medical necessity if drug dosing or indication is outside of FDA guidelines
<input type="checkbox"/> TB lab results within last 12 months (<i>Uplizna only</i>)	

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 - <input type="checkbox"/> 10units/mL ---OR--- <input type="checkbox"/> 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)	<input type="checkbox"/> Epinephrine 0.3mg IM as needed	<input type="checkbox"/> Solu-cortef 250mg-500mg IV as needed
	<input type="checkbox"/> Diphenhydramine _____mg IV as needed	<input type="checkbox"/> NS Hydration 500 ml IV over 30 minutes as needed
		<input type="checkbox"/> Solu-Medrol 60mg - 125mg IV as needed
		<input type="checkbox"/> Other _____
Pre-Medications: (Check all that apply)	<input type="checkbox"/> Acetaminophen _____mg PO _____minutes prior to infusion	<input type="checkbox"/> Solu-Medrol _____mg IV _____minutes prior to infusion
	<input type="checkbox"/> Diphenhydramine _____mg <input type="checkbox"/> PO ---OR--- <input type="checkbox"/> IV _____minutes prior to infusion	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was last dose given? _____ When is patient due for next dose? _____		
<input type="checkbox"/> KINSULA	<input type="checkbox"/> Induction: 700mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over 30 minutes every 4 weeks x 3 doses <input type="checkbox"/> Maintenance: 1400mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over 30 minutes every 4 weeks <input type="checkbox"/> If missed dose, administer the same dose as soon as possible and continue every 4 weeks	NONE
<input type="checkbox"/> RADICAVA	<input type="checkbox"/> Induction: 60mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over 1 hour daily for 14 days followed by 14 day drug-free period <input type="checkbox"/> Maintenance: 60mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over 1 hour daily for 10 days out of 14 day period followed by 14 day drug-free periods	NONE
<input type="checkbox"/> UPLIZNA	<input type="checkbox"/> Induction: 300mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over approximately 90 minutes at 0 and 2 weeks and <i>CBC lab testing every _____ months</i> <input type="checkbox"/> Maintenance: (<i>starting 6 months from first infusion</i>) 300mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over approximately 90 minutes every 6 months	NONE
<input type="checkbox"/> VYEPTI	<input type="checkbox"/> 100mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over approximately 30 minutes every 12 weeks <input type="checkbox"/> 300mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over approximately 30 minutes every 12 weeks	
<input type="checkbox"/> VYVGART	10mg/kg IV infusion via <input type="checkbox"/> gravity ---OR--- ---OR--- pump over at least 1 hour once every week for 4 weeks <i>*Up to max of 1200mg for patient weight of 120kg+ (Total volume is 125ml in NS solution)</i> Administer additional treatment cycles <input type="checkbox"/> every 50 days ---OR--- <input type="checkbox"/> 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.	
<input type="checkbox"/> 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 <input type="checkbox"/> every 50 days ---OR--- <input type="checkbox"/> 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.	
<input type="checkbox"/> IG	Refer to Immunoglobulin Form	
<input type="checkbox"/> SOLIRIS/ULTOMIRIS	Refer to Soliris or Ultomiris Order Form	
<input type="checkbox"/> 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	Print Name	Date	Prescriber's Signature	Print Name	Date
Dispense as Written			Substitution Permitted		

