Neurology Order Form

amerita
specialty infusion services

Fax Completed Form To: 844-815-2606

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?_____		
☐ 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 ☐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	***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 **Print Name** **Date**
Dispense as Written

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

URAC ACCREDITED Specialty Pharmacy Expires 08/01/2021 ACHC ACHC ACCREDITED PCAB ACCREDITED Compounding Pharmacy