

Neurology Order Form

Fax Completed Form To:

Phone:

Amerita
YOUR INFUSION ADVOCATE

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)		☐ Vaccine status (any vaccination) and documentation of any recent vaccinations	
☐ Recent office visit notes, history & physical, lab & pertinent procedure results		☐ HBV lab results within last 12 months (<i>Uplizna only</i>)	
☐ Current medication list & list of prior medications tried and failed (with dates)		☐ Date of diagnosis, current FVC%, ALSFRS-R score, and JourneyMate form (<i>Radicava only</i>)	
☐ Line access documentation/verification if applicable		☐ Anti-acetylcholine receptor (AChR) antibody positive results (<i>Vyvgart</i>)	
☐ Quantitative serum Immunoglobulin lab results (<i>Uplizna only</i>)		☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
☐ 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 - ☐ 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: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed			
(Check all that apply) ☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other			
Pre-Medications: ☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV _____ minutes prior to infusion			
(Check all that apply) ☐ 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	☐ Week 0 (first dose): 350mg IV x 1 dose. Week 4: 700mg IV x 1 dose. Week 8: 1,050mg x 1 dose. Week 12 and thereafter: 1,400mg once every 4 weeks via ☐ gravity - OR - ☐ pump over 30 minutes. Consider discontinuation when amyloid plaques are reduced to minimal levels on amyloid PET imaging. ☐ If missed dose, administer the same dose as soon as possible and continue every 4 weeks		NONE
☐ RADICAVA	☐ Induction: 60mg IV infusion via ☐ gravity ---OR--- ☐ pump over 1 hour daily for 14 days followed by 14 day drug-free period ☐ 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		NONE
☐ UPLIZNA	☐ Induction: 300mg IV infusion via ☐ gravity ---OR--- ☐ pump over approximately 90 minutes at 0 and 2 weeks and CBC lab testing every _____ months ☐ Maintenance: (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--- ☐ 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	☐ Vial: 1008mg/11,200units SC over approx. 30-90 seconds once weekly for _____ weeks. ☐ Syringe: 1000mg/10,000units SC over approx. 30-90 seconds once weekly for _____ 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		
☐ 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

