

NEUROLOGY

New Prescription/Referral

Prescription Refill

# Of Refills:

RX:

Patient Name:

Patient Weight:

kg

DOB:

Diagnosis:	<b>Soliris (eculizumab) :</b>	900mg IV weekly for the 1st 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg every 2 weeks thereafter x1 year (initial start with maintenance)			
ICD-10:	(neuro dosing)	1200mg IV every 2 weeks x1 year (maintenance dosing)			
Multiple Sclerosis ICD-10:	<b>Tysabri (natalizumab)</b>	300mg IV every 4 weeks x1 year (after registering patient with TOUCH)			
	<b>Ocrevus (ocrelizumab):-</b>	Initial dose 300mg IV for 2.5 hrs			
	(*Pre-Medications Required)	2nd dose 300mg IV for 2.5 hrs to be given after 2 weeks			
	Others:	-----			
	<b>Ocrevus Zunovo:</b>	920mg/23,000units subcutaneously every 6 months x1 year			
	<b>Premed protocol:</b>	dexamethasone 20mg PO & cetirizine 10mg PO 30 minutes prior to Ocrevus Zunovo			
	<b>Briumvi (ublituximab-xiiv):</b>	Initial dose 150mg IV then 450mg IV two weeks later			
	(*Pre-Medications Required)	Maintenance dose 450mg IV 24 weeks after the first infusion & every 24 weeks			
Diagnosis:	<b>IVIg:</b>	Gamunex (10%)	Privigen (10%)	Octagam (10%)	Gammaflex (10%)
		Gammagard (10%)	Bivigam (10%)	Gammaked(10%)	Flebogamma DIF (10%)
		Asceniv (10%)	Panzyga (10%)		
ICD-10:	<b>Dosage:</b>	-----gm/day	-----mg/kg	-----# of days	-----# of months
	<b>Frequency:</b>	One-Time Only      every ----- weeks (Optional: Start Date -----)			
Migraines ICD-10:	<b>Vyepti (eptinezumab-jjmr):</b>	100 mg IV every 3 months x1 year	300 mg IV every 3 months x1 year		
Myasthenia Gravis ICD-10	<b>Ultomiris:</b>	Initial dose (40-59kg) 2,400mg IV, followed by 3,000mg IV 2 weeks later, then 3,000mg IV every 8 weeks			
	(ravulizumab-cwvz) :	(60-99kg) 2,700mg IV, followed by 3,300mg IV 2 weeks later, then 3,300mg IV every 8 weeks			
		(100kg+) 3,000mg IV, followed by 3,600mg IV 2 weeks later, then 3,600mg IV every 8 weeks			
	Maintenance dose	(40-59kg) 3,000mg      (60-99kg) 3,300mg      (100kg+) 3,600mg IV every 8 weeks			
	<b>Vyvgart:</b>	(<120kg) 10mg/kg IV once weekly for 4 weeks      (≥120kg) 1200mg IV over 1 hour once weekly for 4 weeks			
CIDP (Vyvgart Hytrulo) ICD-10:	(efgartigimod	May repeat for ----- cycles (scheduled greater than 50 days from start of previous cycle)			
	alfa-fcab)	**Please provide clinical notes discussing need for recurrent cycles**			
	<b>Vyvgart Hytrulo:</b>	1,008 mg / 11,200 units subcutaneously weekly x 4 weeks (Myasthenia Gravis)			
	(efgartigimod alfa and	May repeat for ----- cycles (scheduled greater than 50 days from start of previous cycle)			
	hyaluronidase-qvfc)	**Please provide clinical notes discussing need for recurrent cycles**			
		1,008 mg / 11,200 units subcutaneously weekly (CIDP)			
Pompe Disease ICD-10:	<b>Rystiggo:</b>	(<50kg) 420mg SubQ weekly x 6      (50kg - 100kg) 560mg SubQ weekly x 6			
	(rozanolixizumab-noli)	(≥100kg) 840mg subQ weekly x6			
		May repeat for ----- cycles (scheduled greater than 63 days from start of previous cycle)			
	**Please provide clinical notes discussing need for recurrent cycles**				
	<b>Lumizyme:</b>	20mg/kg IV every 2 weeks x1 year		<b>Nexviazyme:</b>	20mg/kg IV every 2 weeks x1 year
	(alglucosidase alfa)			(avalglucosidase alfa)	
<b>Pre-Medication:</b>					
		Zofran:	4mg      8mg IVP	Pepcid IV 20mg IVP	
Solumedrol 125mg IVP		Tylenol ----- mg PO		Benadryl ----- mg PO	<b>ANA Kit Protocol:</b>
Solu-Cortef 100mg IVP		650 mg      975 mg		25 mg      IV	
Others: -----				50 mg      PO	
<b>Physician Signature</b>		<b>NPI #:</b>		<b>DATE:(Valid for 1 year)</b>	
By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.					
<b>PHYSICIAN INFORMATION</b>					
<b>Physician Name:</b>			<b>Clinic:</b>		
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>	<b>Other:</b>		
<b>Office Mailing Address:</b>					
<b>Please include the following.</b>	Patient demographics	Insurance attached	Diagnosis(supporting)	History & Physical	
	Lab Results	Clinical progress notes	Medication list	Other Test Results	
Serum Immunoglobulins (Ocrevus & Brriumvi)		AChR antibody (Rystiggo, Vyvgart & Ultomiris) or MuSK antibody (Rystiggo)			
Hep B antigen & Hep B core total (Ocrevus & Brriumvi)		MRI documentation (Tysabri, Ocrevus, Brriumvi)			
JCV antibody (Tysabri)		CBC & CMP (Ocrevus & Tysabri)		Men ACWY & Men B vaccines (Ultomiris & Soliris)	
We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot					