NEUROLOGY

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

RX: Patient Name: | Patient Weight: kg | DOB:

Diagnosis:

ICD-10:

Soliris (eculizumab): (neuro dosing)
- ☐ 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 (inital start with maintenance)
- ☐ 1200mg IV every 2 weeks x1 year (maintenance dosing)

Multiple Sclerosis
ICD-10:

Tysabri (natalizumab) ☐ 300mg IV every 4 weeks x1 year (after registering patient with TOUCH)

Ocrevus (ocrelizumab): (*Pre-Medications Required)
- ☐ Initial dose 300mg IV for 2.5 hrs
- ☐ 2nd dose 300mg IV for 2.5 hrs to be given after 2 weeks
- ☐ Other:_____

Ocrevus Zunovo: ☐ 920mg/23,000units subcutaneously every 6 months x1 year

(*Premed protocol:)
- ☐ ***Dexamethasone (or equivalent corticosteroid):*** 20mg administered orally at least 30 mins prior to administration
- ☐ ***Antihistamine (e.g., desloratadine):*** Administered orally at least 30 mins prior to administration to reduce the risk of local and systemic injection reactions
- ☐ ***Antipyretic (e.g., acetaminophen):*** The addition of an antipyretic may also be considered
- ☐ *Other:*_____

Briumvi (ublituximab-xiiy): (*Pre-Medications Required)
- ☐ Initial dose 150mg IV then 450mg IV two weeks later
- ☐ Maintenance dose 450mg IV 24 weeks after the first infusion & every 24 weeks

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Diagnosis:

ICD-10:

IVIG:
- ☐ Gamunex (10%)
- ☐ Privigen (10%)
- ☐ Octagam (10%)
- ☐ Gammaplex (10%)
- ☐ Gammagard (10%)
- ☐ Bivigam (10%)
- ☐ Gammaked(10%)
- ☐ Flebogamma DIF (10%)
- ☐ Asceniv (10%)
- ☐ Panzyga (10%)
- ☐ Other Orders:_____

Dosage: ☐ _____g/day IV ☐ _____g/kg IV ☐ Over _____# of days ☐ _____# of months

Frequency: ☐ One-Time Only ☐ every _____ weeks (Optional: Start Date _____)

Migraines
ICD-10:

Vyepti (eptinezumab-jjmr): ☐ 100 mg IV every 3 months x1 year ☐ 300 mg IV every 3 months x1 year

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Myasthenia Gravis
ICD-10

Ultomiris: (ravulizumab-cwvz):
- ☐ Initial dose ☐ (40-59kg) 2,400mg IV, followed by 3,000mg IV 2 weeks later, then 3,000mg IV every 8 weeks
- ☐ (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

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CIDP (Vyvgart Hytrulo)
ICD-10:

Vyvgart: (efgartigimod alfa-fcab) ☐ (<120kg) 10mg/kg IV once weekly for 4 weeks ☐ (≥120kg) 1200mg IV over 1 hour once weekly for 4 weeks
- ☐ May repeat for ____ cycles (scheduled greater than 50 days from start of previous cycle)
  Please provide clinical notes discussing need for recurrent cycles

Vyvgart Hytrulo: (efgartigimod alfa and hyaluronidase-qvfc)
- ☐ 1,008 mg / 11,200 units subcutaneously weekly x 4 weeks **(Myasthenia Gravis)**
- ☐ May repeat for ____ cycles (scheduled greater than 50 days from start of previous cycle)
  Please provide clinical notes discussing need for recurrent cycles
- ☐ 1,008 mg / 11,200 units subcutaneously weekly **(CIDP)**

Rystiggo: (rozanolixizumab-noli)
- ☐ (<50kg) 420mg SubQ weekly x 6 ☐ (50kg - 100kg) 560mg SubQ weekly x 6
- ☐ (≥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

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Pre-Medication:

☐ Zofran: ☐ 4mg ☐ 8mg IVP

☐ Pepcid IV 20mg IVP

☐ Solumedrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:
☐ OK to use

Physician Signature | **NPI #:** | **DATE:(Valid for 1 year)**

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.

PHYSICIAN INFORMATION

Physician Name: | **Clinic:**

Phone: | **Fax:** | **Email:** | **Other:**

Office Mailing Address:

Please include the following
- ☐ Patient demographics
- ☐ Insurance attached
- ☐ Diagnosis(supporting)
- ☐ History & Physical
- ☐ Lab Results
- ☐ Clinical progress notes
- ☐ Medication list
- ☐ Other Test Results
- ☐ Serum Immunoglobulins (Ocrevus & Briumvi)
- ☐ AChR antibody (Rystiggo, Vyvgart & Ultomiris) or MuSK antibody (Rystiggo)
- ☐ Hep B antigen & Hep B core total (Ocrevus & Briumvi)
- ☐ MRI documentation (Tysabri, Ocrevus, Briumvi)
- ☐ 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