☐ *Need a referral status update, Please provide your email below*

***Patient Insurance & ID (front and back) are needed**

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

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

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

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

CIDP (Vyvgart Hytrulo)
ICD-10:

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

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