# NEUROLOGY

**FAX:** 725.228.5220

☐ New Prescription/Referral
☐ Prescription Refill

eMediate INFUSION

**# Of Refills:**

## PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

| Name: | DOB: | Weight: kg |
|---|---|---|

## PHYSICIAN INFORMATION

| Prescriber Name: | Phone: | Fax: |
|---|---|---|
| Office Contact: | *Email (for the referral update): | |
| Clinic: | Address: | |
| NPI: | | |
| Patient's PCP Name: | Phone: | Fax: |
| Clinic: | Address: | |
| NPI: | | |

## PRESCRIPTION INFORMATION (or attach a copy of the prescription)

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:** ( *Premed protocol: )

- ☐ 920mg/23,000units subcutaneously every 6 months x1 year
- ☐ ***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

CIDP (Vyvgart Hytrulo)
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**

**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:

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others: _____

- ☐ Zofran: ☐ 4mg ☐ 8mg IVP
- ☐ Tylenol _____ mg PO
  - ☐ 650 mg 975 mg

- ☐ Pepcid IV 20mg IVP
- ☐ Benadryl _____ mg PO
  - ☐ 25 mg ☐ IV
  - ☐ 50 mg ☐ PO

**ANA Kit Protocol:**

☐ OK to use

**PRESCRIBER SIGNATURE: x**

Date (Valid for 1 year):

*I authorize eMediate Infusion Center, PLLC , Assist Point Clinical or its authorized representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to eMediate Infusion Center.*

# NEUROLOGY

**FAX:** 725.228.5220 eMediate INFUSION

## PATIENT INFORMATION

Name: DOB:

## REQUIRED INFORMATION ( please attach )

- ☐ **Patient demographics**
- ☐ **Insurance attached**
- ☐ **Diagnosis(supporting)**
- ☐ **History & Physical**
- ☐ **Lab Results**
- ☐ **Clinical progress notes**
- ☐ **Medication list**
- ☐ **Other Test Results**

- ☐ Serum Immunoglobulins (Ocrevus & Briumvi)
- ☐ CBC & CMP (Ocrevus & Tysabri)
- ☐ JCV antibody (Tysabri)
- ☐ Hep B antigen & Hep B core total (Ocrevus & Briumvi)
- ☐ AChR antibody (Rystiggo, Vyvgart & Ultomiris) or MuSK antibody (Rystiggo)
- ☐ MRI documentation (Tysabri, Ocrevus, Briumvi)
- ☐ 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**