Lotus Health Houston Neurology Order Form

Phone: 832-284-4452| Fax: 877-643-0993

PATIENT INFORMATION *Demographics attached*

Patient Name: DOB: Phone:

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight:_____lbs. Allergies:_____

Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Last MRI documentation attached

Patient's TOUCH authorization (only for Tysabri orders)

Hepatitis B antigen and Hepatitis B Core total antibody required (only for Ocrevus orders)

Confirmed Presence of amyloid pathology (CSF or PET scan) attached (only for Aduhelm orders)

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

INFUSION ORDERS

Alzheimer's Disease
ICD-10: _____

Administer Aduhelm IV every 4 weeks as follows (Select One):

Initial start w/ maintenance dosing:

- 1mg/kg for infusion 1 and 2
- 3mg/kg for infusion 3 and 4
- 6mg/kg for infusion 5 and 6
- 10 mg/kg for infusion 7 and beyond

Maintenance doing only: 10mg/kg

Migraines
ICD-10: _____

Pre-Medication: Zofran 4mg slow IVP Zofran 8mg IVP Pepcid IV 20mg IVP Toradol 30mg IVPSolu-Medrol 125mg IVP Reglan 10mg IV/100mL NS over 20 minutes Benadryl 25mg IV

Protocol: Depacon 500mg 750mg IV in 250mL NS

Magnesium Sulfate 1gm IV in 250mL

DHE 45 0.5mg 1mg IV in 100mL NS *(must premed for nausea)*

Standing PRN Order: 1 month 2 months 3 months Repeat regimen daily for_____days

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Migraines
ICD-10: _____

Vyepti: 100mg IV every 3 months

300mg IV every 3 months

Multiple Sclerosis Exacerbation
ICD-10: _____

Solu-Medrol 1gm IV daily x_____daysSolu-Cortef 1gm IV daily x_____days

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Multiple Sclerosis
ICD-10: _____

Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH)
Pre-medication protocol: Tylenol 1000mg PO and Benadryl 25mg PO

Ocrevus 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months 600mg IV every 6 months
Pre-Medication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion

IVIG ORDERS

Diagnosis:_____ICD-10:_____ IVIG Brand: _____ IVIG Orders: mg/kg OR gm/kg IV divided over day(s)

Frequency: Every_____weeks **OR**_____one time dose only

Protocol Pre-Medication Orders: Tylenol 1000mg PO

please choose one antihistamine: Cetirizine 10mg PO Diphenhydramine 25mg PO Loratadine 10mg PO

Additional Pre-Medication Orders: Solu-Medrol_____mg - IVP

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Lotus Health Houston and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: Fax: Contact Person