

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Email: \_\_\_\_\_

## Neurology Referral Form

*Please attach copy of insurance cards (front and back)*

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	City: State: Zip:
Phone:	SSN:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name:

### Insurance Information

Insurance Plan:	Insurance Plan:	Prescriber NPI:
Policy #	Policy #	Nurse/Key Contact:
Plan I.D. #	Plan I.D. #	Phone: Fax:
		Email:

### Diagnosis and Clinical Information

*Please attach clinical/progress notes and test results supporting primary diagnosis*

Diagnosis	ICD-10 Code	Allergies:
1.		
2.		
3.		
4.		NKDA:
5.		Height:
6.		Weight:

### Labs

Test	Frequency

### Nursing Orders

Skilled nurse to assess and administer and/or teach self-administration where appropriate. Nurse to provide ongoing support as needed x 1 year.

### Prescription Information

Medication	Directions	QTY	Refills
<input type="checkbox"/> IVIg	Administer _____ gm/kg per day for _____ days every _____ weeks		
<input type="checkbox"/> SCIg	Administer _____ gm/kg per day for _____ days every _____ weeks		
<input type="checkbox"/> Aduhelm (aducanumab-avwa)	IV every 4 weeks as follows: 1 mg/kg for infusions 1 and 2; 3 mg/kg for Infusions 3 and 4 6mg/kg for infusions 5 and 6; 10mg/kg for infusions 7 and beyond		
<input type="checkbox"/> Briumvi (ublituximab)	First infusion: 150mg IV infusion Second infusion: 450mg IV infusion at 2 weeks after first infusion Followed by 450mg IV every 24 weeks		
<input type="checkbox"/> Kisunla (donanemab-azbt)	700mg administered over approximately 30 minutes every 4 weeks for the first three doses Followed by 1,400mg every 4 weeks thereafter		
<input type="checkbox"/> Lemtrada (alemtuzumab)	First infusion: 12mg IV infusion for 5 consecutive days Second infusion: 12mg IV infusion for 3 consecutive days 12 months after first infusion		
<input type="checkbox"/> Leqembi (lecanemab-irmb)	10mg/kg IV every 2 weeks *MRIs at baseline, prior to 5th, 7th and 14th infusions		
<input type="checkbox"/> Ocrevus (ocrelizumab)	Starting dose: Infuse 300mg IV on day 1 and day 15 Maintenance dose: Infuse 600mg IV once every 6 months		
<input type="checkbox"/> Radicava (edaravone)	Starting dose: 60mg IV daily for 14 days followed by a 14-day drug-free period Maintenance dose: 60mg IV daily for 10 days out of 14 followed by a 14-day drug-free period		
<input type="checkbox"/> Rystiggo (rozanolixizumab)	<input type="checkbox"/> <50kg = 420mg <input type="checkbox"/> 50kg to <100kg = 560mg <input type="checkbox"/> >100 = 840mg *Cycle may be repeated > 63 days Dose above once weekly x 6 weeks.		
<input type="checkbox"/> Soliris (eculizumab)	Starting dose: 900mg IV weekly for 4 weeks, followed by 1,200mg IV for the fifth dose 1 week later Maintenance dose: 1,200mg IV every 2 weeks		

## Prescription Information, continued

Medication	Directions	QTY	Refills
<input type="checkbox"/> Tysabri (natalizumab)	Infuse 300mg IV every 4 weeks		
<input type="checkbox"/> Ultomiris (ravulizumab)	<input type="checkbox"/> 40-59kg Starting dose: 2,400mg IV followed in 2 weeks by maintenance dose of 3,000mg IV every 8 weeks <input type="checkbox"/> 60-99kg Starting dose: 2,700mg IV followed in 2 weeks by maintenance dose of 3,300mg IV every 8 weeks <input type="checkbox"/> ≥ 100kg Starting dose: 3,000mg IV followed in 2 weeks by maintenance dose of 3,600mg IV every 8 weeks		
<input type="checkbox"/> Uplizna (inebilizumab-cdon)	Starting dose: 300mg IV followed by 300mg at 2 weeks Maintenance dose: 300mg IV starting 6 months after first infusion		
<input type="checkbox"/> Vyepti (eptinezumab-jjmr)	<input type="checkbox"/> 100mg IV every 12 weeks <input type="checkbox"/> 300mg IV every 12 weeks		
<input type="checkbox"/> Vyvgart (efgartigimod alfa)	10mg/kg (1,200mg for weight >120kg) IV once weekly for _____ weeks with _____ weeks between cycles		
<input type="checkbox"/> Vyvgart-Hytrulo (efgartigimod alfa and hyaluronidase-QVFC)	<input type="checkbox"/> Myasthenia gravis: 1,008mg efgartigimod alfa/11,200 units hyaluronidase once weekly for 4 weeks <input type="checkbox"/> CIDP: 1,008mg efgartigimod alfa/11,200 units hyaluronidase once weekly (indefinitely)		
<input type="checkbox"/> Other			

## Pre-medication

<input type="checkbox"/> NS Hydration	_____ mLs NS IV to be infused prior/post infusion
<input type="checkbox"/> Acetaminophen	1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed <input type="checkbox"/> 50mg IV prior to infusion or as directed
<input type="checkbox"/> Anaphylaxis	Anaphylaxis per pharmacy protocol
<input type="checkbox"/> Other	

I authorize Vital Care Infusion Services LLC and its 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 Vital Care.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED**

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