



NEUROLOGY REFERRAL FORM

****Please Attach Copy of Insurance Cards (Front & Back)****

| | | | | | |
|------------------------------|--------|-----------------|------|--------------------|-----------------|
| Last Name: | | First Name: | | DOB: | Practice: |
| Address: | | | | Address: | |
| City: | State: | Zip: | Sex: | M | F |
| Phone: | SSN# | | | Prescriber Name: | |
| INSURANCE INFORMATION | | | | | Prescriber NPI: |
| Insurance Plan: | | Insurance Plan: | | Nurse/Key Contact: | |
| Policy # | | Policy # | | Phone: | |
| Plan I.D. # | | Plan I.D. # | | Fax: | Email: |

DIAGNOSIS & CLINICAL INFORMATION

****Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis****

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

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"/> 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"/> Tysabri (natalizumab) | Infuse 300mg IV every 4 weeks | | |
| <input type="checkbox"/> Briumvi (ublituximab) | First infusion: 150mg IV infusion Second infusion: 450mg IV infusion at 2 weeks after 1st infusion Followed by 450mg IV every 24 weeks x 1 year | | |
| <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"/> Vyvgart (efgartigimod alfa) | 10mg/kg IV once weekly for 4 weeks (<120kg) 1200mg/kg IV once weekly for 4 weeks (<120kg) 1200mg for weight >120kg. *Cycle may be repeated > 50 days from start of previous cycle. | | |
| <input type="checkbox"/> Vyvgart- Hytrulo (efgartigimod alfa and hyaluronidase-QVFC) | 1,008mg /11,200 units subcutaneously weekly for 4 weeks | | |
| <input type="checkbox"/> Rystiggo (ozanimod) | <50kg=420mg 50kg to <100kg = 560mg >100 = 840mg *Cycle may be repeated > 63 days | | |
| <input type="checkbox"/> Ulimiris (ravulizumab) | Starting dose: 2,400 (40-59kg) 2,700mg (60-99kg) 3,000mg (100kg+) IV followed in 2 weeks by Maintenance dose: 3,000mg (40-59kg) 3,300mg (60-99kg) 3,600mg (100kg+) IV every 8 weeks | | |
| <input type="checkbox"/> Soliris (eculizumab) | Starting dose: 900mg IV weekly for 4 weeks, followed by 1200mg IV for the 5th dose 1 week later Maintenance dose: 1200mg IV every 2 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 1st infusion | | |
| <input type="checkbox"/> Radicava (edaravone) | Starting dose: 60mg IV daily for 14 days followed by 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"/> Vyepi (eptinezumab-jjmr) | 100mg IV every 12 weeks 300mg IV every 12 weeks | | |
| <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"/> Aduhelm (aducanumab-avwa) | IV every 4 weeks as follows: 1mg/kg infusions 1 & 2 3mg/kg infusions 3 & 4 6mg/kg infusions 5 & 6 10mg/kg infusions 7 and beyond | | |
| <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 | _____ Take 1 tablet PO prior to infusion or as directed _____ 50mg IV prior to infusion or as directed |
| <input type="checkbox"/> Anaphylaxis | Anaphylaxis per pharmacy protocol |
| <input type="checkbox"/> Other | |

I authorize Infuse One 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 Infuse One.

Physician Signature: _____

Date: _____

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

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.