



INFUSE ONE

Email to: intake@infuseone.com

Fax to: 888-261-6644

- Palm Beach Gardens
- Melbourne
- Tallahassee
- Fort Lauderdale

Neurology Referral Form

Please Attach Copy of Insurance Cards (Front & Back)

Last Name, First Name: _____

Address: _____

Phone: _____

Referring Practice: _____

Practice Address: _____

Prescriber Name: _____

Nurse/Key Contact: _____

Fax: _____

Date of Birth: _____ Gender: M F Other

City, State, Zip: _____

SSN# _____

City, State, Zip: _____

Prescriber NPI: _____

Phone: _____

Email: _____

Insurance Information

Insurance Plan: _____ Insurance Plan: _____

Policy#: _____ Plan ID: _____ Policy#: _____ Plan ID: _____

Diagnosis & Clinical Information Please attached Clinical/Progress Notes, Labs, Tests, Supporting Primary Diagnosis**

DIAGNOSIS	ICD-10 CODE	
1.		<input type="checkbox"/> Allergies _____
2.		_____
3.		_____
4.		<input type="checkbox"/> NKDA
5.		Height: _____
6.		Weight: _____

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. <i>*Cycle may be repeated > 50 days from start of previous cycle.</i>		
<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 <i>*Cycle may be repeated > 63 days</i>		
<input type="checkbox"/> Ulimirris (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"/> Vyepiti (eptinezumab-ijjm)	100mg IV every 12 weeks 300mg IV every 12 weeks		
<input type="checkbox"/> Leqembi (lecanemab-imb)	10mg/kg IV every 2 weeks <i>*MRIs at baseline, prior to 5th, 7th and 14th infusions</i>		
<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: _____

Provider Phone Line:
833-881-6048

Please be sure to attach all of the following:

- Patient demographics
- Patient medical insurance card copied front and back
- Patient pharmacy card copied front and back (if they have one)
- Most recent chart notes, diagnostic testings, and labs.
- Proof of patient being concurrently treated with any other biologics