NEUROLOGY INFUSION ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Infusion Orders
☐ Pompe Disease **ICD-10:** _____	☐ **Lumizyme** 20mg/kg IV every 2 weeks x 1 year ☐ **Nexviazyme** 20mg/kg IV every 2 weeks x 1 year
☐ Acute Migraines **ICD-10:** _____	**Premedication**: ☐ Zofran 4mg IVP ☐ Zofran 8mg IVP ☐ Pepcid 20mg IVP ☐ Toradol 30mg IVP ☐ Solu-Medrol 125mg IVP ☐ Reglan 10mg IV ☐ Benadryl 25mg IV **Protocol:** ☐ Depacon 500mg ☐ Depacon 750mg IV in250mL NS ☐ Magnesium Sulfate 1gm IV in 250mL NS ☐ DHE 45 0.5mg ☐ DHE 45 1mg IV in 100mL NS (must premed for nausea) Standing PRN Order: ☐ 1 month ☐ 2 months ☐ 3 months Repeat regimen daily for _____ days
☐ Migraines **ICD-10:** _____	☐ **Vyepti** ☐ 100mg IV every 3 months x 1 year **OR** ☐ 300mg IV every 3 months x 1 year ☐ **Robaxin** ☐ 1000mg IV every 2 weeks x 1 year **OR** ☐ 1500mg IV every 2 weeks x 1 year
☐MS ☐Other: _____ **ICD-10:** _____	☐ **Solu-Medrol** 1gm IV daily x _____ days ☐ **Solu-Cortef** 1gm IV daily x _____ days
☐ Diagnosis: _____ **ICD-10:** _____	☐ **Soliris** ☐ 900mg IV weekly for the first 4 weeks, followed by 1200mg for 5th dose 1 week later, then 1200mg every 2 weeks thereafter x 1 year **(initial start with maintenance)** ☐ 1200mg IV every 2 weeks x 1 year **(maintenance dosing)**
☐ Multiple Sclerosis **ICD-10:** _____	☐ **Tysabri** 300mg IV every 4 weeks *(after registering patient with TOUCH program)* ☐ **Ocrevus*** ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x 1 year **(initial start with maintenance)** ☐ 600mg IV every 6 months x 1 year **(maintenance dosing)** ☐ **Briumvi*** ☐ 150mg IV x 1 dose, then 450mg IV 2 weeks later, then every 24 weeks **(initial start with maintenance)** ☐ 450mg IV every 24 weeks x 1 year **(maintenance dosing)** ***Premedication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO/IV to be given 30 minutes before infusion**
☐ Diagnosis: _____ **ICD-10:** _____	☐ **IVIg** Orders: _____ mg/kg **OR** _____ mg/kg IV divided over _____ day(s) **Frequency**: Every _____ weeks x 1 year **OR** _____ one time dose only Preferred Brand: _____ *Active Infusions to choose if not indicated*
☐ Myasthenia Gravis **ICD-10:** _____	☐ **Ultomiris** ☐ Loading Dose: ☐ 2400mg (40-59kg) ☐ 2700mg (60-99kg) ☐ 3000mg (>100kg) IV followed 2 weeks later by ☐ Maintenance dose: ☐ 3000mg (40-59kg) ☐ 3300mg (60-99kg) ☐ 3600mg (>100kg) IV every 8 weeks x 1 year ☐ **Vyvgart** ☐ 10mg/kg (<120kg) OR ☐ 1200mg (>120kg) IV once weekly for 4 weeks
☐ hATTR amyloidosis **ICD-10:** _____	☐ **Amvuttra** 25 SubQ every 3 months x 1 year

Premedication orders: Tylenol ☐ 1000mg OR ☐ 500 mg PO
Please choose one antihistamine: ☐ Diphenhydramine 25mg PO / IV ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Other: _____
Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____