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: _____

Patient Status: ☐New to Therapy ☐Continuing Therapy **Next Treatment Date:** _____

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
☐ Migraines **ICD-10:** _____	☐ **Vyepti** ☐ 100mg IV every 3 months x 1 year **OR** ☐ 300mg IV every 3 months 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 ☐ 600mg IV every 6 months x 1 year ☐ **Ocrevus Zunovo** 920mg/23,000 units subcutaneously every 6 months x 1 year Premed protocol: dexamethasone 20mg PO & cetirizine 10 mg PO 30 minutes prior to Ocrevus Zunovo ☐ **Briumvi*** ☐ 150mg IV x 1 dose, then 450mg IV 2 weeks later, then 450mg IV every 24 weeks ☐ 450mg IV every 24 weeks x 1 year ***Premedication Protocol: Solu-Medrol 100 mg 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:** _____ ☐ CIDP (Vyvgart Hytrulo) **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 *Cycle may be repeated >50 days from start of previous cycle. Subsequent cycles may be ordered as appropriate **Vyvgart Hytrulo*:** ☐ 1008mg/11200 units subQ. Frequency: ☐ weekly for 4 weeks* **OR** ☐ every week x 1 year *Cycle may be repeated >50 days from start of previous cycle. Subsequent cycles may be ordered as appropriate **Rystiggo**:** ☐<50kg: 420 mg ☐50 kg to <100 kg: 560 mg ☐≥100 kg: 840 mg subQ weekly x 6 doses **Cycle may be repeated ≥63 days from start of previous cycle. Subsequent cycles may be ordered as appropriate **Imaavy:** ☐ Initial start: 30mg/kg IV x 1, then 15mg/kg IV 2 weeks later, then 15mg/kg IV every 2 weeks thereafter x 1 year ☐ Maintenance dose: 15 mg/kg IV every 2 weeks x 1 year
☐ hATTR amyloidosis **ICD-10:** _____	☐ **Amvuttra** 25 SubQ every 3 months x 1 year

Premedication orders: Tylenol ☐ 1000mg OR ☐ 500 mg PO OR ☐ 650 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: _____

ACTIVE infusions

COMPREHENSIVE SUPPORT FOR NEUROLOGY THERAPY
P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete previous page)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's mediation list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis

  Has the patient tried and failed previous drug therapy?

  If yes, which drugs? _____
- ☐ Labs Attached
  - ☐ JCV antibody (Tysabri orders)
  - ☐ AChR antibody or MuSK antibody (Rystiggo, Imaavy, Vyvgart, & Ultomiris)
  - ☐ Hepatitis B antigen and Hepatitis B core total antibody (Ocrevus & Briumvi)
  - ☐ Serum immunoglobulins (Ocrevus & Briumvi)
  - ☐ Other supporting labs based on diagnosis/order
- ☐ Diagnostic testing
  - ☐ MRI documentation (Tysabri, Ocrevus, Briumvi)
  - ☐ Other diagnostic testing to support diagnosis/order
- ☐ Vaccine record
  - ☐ Meningococcal vaccinations – both Men B and Men ACWY (Soliris & Ultomiris)
- ☐ Other medical necessity: _____

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance

ACTIVEINFUSIONS.COM