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)** ☐ **Ocrevus Zunovo** 920mg/23,000 units subcutaneously every 6 months x 1 year ***Premed Protocol:** Note-Dexamethasone 20mg PO or equivalent oral corticosteroid requires a written prescription from the ordering provider, patient must fill prior to appointment. **Cetirizine 10mg PO (Active Infusions will supply in clinic) – 30 min prior*** ☐ **Briumvi*** 150mg IV x 1 dose, then 450mg IV 2 weeks later, then 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:** _____	□ **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 the 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: _____

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
- ☐ Include patient demographic information and insurance information page)
- ☐ 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)
- ☐ 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@actoveinfusions.com for assistance

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

☐ Phone Call ☐ Text Message ☐ Email ☐ No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder? ☐ Yes ☐ No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION