vitalcare® INFUSION SERVICES

Pharmacy:	Phone:
Address:	Fax:
City/State/Zip:	Email:

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	City:	State:	Zip:
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
1.	
2.	
3.	
4.	
5.	
6.	

Allergies:

NKDA:

Height:

Weight:

PRESCRIPTION INFORMATION

Medication	Directions	QTY	Refills
☐ IVIG	Administer ____ gm/kg per day for ____ days every ____ weeks		
☐ SCIG	Administer ____ gm/kg per day for ____ days every ____ weeks		
☐ Ocrevus *(ocrelizumab)*	Starting dose: Infuse 300mg IV on day 1 and day 15 Maintenance dose: Infuse 600mg IV once every 6 months		
☐ Tysabri *(natalizumab)*	Infuse 300mg IV every 4 weeks		
☐ 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		
☐ 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		
☐ 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.*		
☐ Vyvgart- Hytrulo *(efgartigimod alfa and hyaluronidase-QVFC)*	1,008mg /11,200 units subcutaneously weekly for 4 weeks		
☐ Rystiggo *(rozanolixizumab)*	<50kg=420mg 50kg to <100kg = 560mg >100 = 840mg *Cycle may be repeated > 63 days*		
☐ Ultomiris *(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		
☐ 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		
☐ Uplizna *(inebilizumab-cdon)*	Starting dose: 300mg IV followed by 300mg at 2 weeks Maintenance dose: 300mg IV starting 6 months after 1st infusion		
☐ 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.		
☐ Vyepti *(eptinezumab-jjmr)*	100mg IV every 12 weeks 300mg IV every 12 weeks		
☐ Leqembi *(lecanemab-irmb)*	10mg/kg IV every 2 weeks *MRIs at baseline, prior to 5th, 7th and 14th infusions*		
☐ 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		
☐ Other			

PRE-MEDICATION

☐ NS Hydration	_____ mls NS IV to be infused prior/post infusion
☐ Acetaminophen	1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	_____ Take 1 tablet PO prior to infusion or as directed _____ 50mg IV prior to infusion or as directed
☐ Anaphylaxis	Anaphylaxis per pharmacy protocol
☐ Other	

I authorize Vital Care Infusion Services LLC 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 Vital Care.

Physician Signature: _____

Date: _____

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