

Last Name: Address: City:

Insurance Plan: Policy # Plan I.D. #

DIAGNOSIS

Medication

IVIG 

1 2. 3. 4. 5. 6.

Phone:

Address:

/ICES	City/State/

City/State/Zip:

**NEUROLOGY REFERRAL FORM** 

	NEURULUGY	REFERRAL FURIN						
	**Please Attach Copy of I	nsurance Cards (Front & Ba	ck)**					
st Name:	First Name:	DOB:	Pr	ractic	e:			
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/:	State: Zip:	Sex: M F	: Ci	ity:		State:	Zip:	
one:	SSN#		Pi	rescri	ber Name:			
	INSURANCE INFORMATION		Pi	rescri	ber NPI:			
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n I.D. #	Plan I.D. #		Fa	ax:		Email:		
	DIAGNOSIS & CLINI	CAL INFORMATIO	N					
** <b>Please</b> IAGNOSIS	Attach Clinical/Progress Notes, Labs, Test, Supporting Primary	<b>y Diagnosis**</b> ICD-10 Code	e		Allergies:			
					NKDA:			
					Height:			
					Weight:			
·	PRESCRIPTION	NFORMATION			- J -			
/ledication	Directions					QTY	Re	efills
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 infus Followed by 450mg IV every 24 weeks x 1 year	sion at 2 weeks after 1st infu	sion					
Lemtrada (alemtuzumab)	First infusion: 12mg IV infusion for 5 consecutive days Second infusion: 12mg IV infusion for 3 consecutive days 12 mon	ths after first infusion						
Vyvgart (efgartigimod alfa)	10mg/kg IV once weekly for 4 weeks (<120kg) 1200mg/kg IV or *Cycle may be repeated > 50 days from start of previous cycle.	nce weekly for 4 weeks (<120	kg) 120	00mg 1	or weight >120kg			
Vyvgart- Hytrulo	1.008mg /11.200 units subcutaneously weekly for 4 weeks							

Phone:

Email:

Fax:

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.		
1,008mg /11,200 units subcutaneously weekly for 4 weeks		
<50kg=420mg 50kg to <100kg = 560mg >100 = 840mg *Cycle may be repeated > 63 days		
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		
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		
Starting dose: 300mg IV followed by 300mg at 2 weeks Maintenance dose: 300mg IV starting 6 months after 1st infusion		
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.		
100mg IV every 12 weeks 300mg IV every 12 weeks		
10mg/kg IV every 2 weeks *MRIs at baseline, prior to 5th, 7th and 14th infusions		
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		
PRE-MEDICATION		
mls NS IV to be infused prior/post infusion		
1-2 tablets PO prior to infusion or post-infusion as directed		
Take 1 tablet PO prior to infusion or as directed 50mg IV prior to infusion or as directed		
Anaphylaxis per pharmacy protocol		
	*Cycle may be repeated > 50 days from start of previous cycle.    1,008mg /11,200 units subcutaneously weekly for 4 weeks    <50kg=420mg	*Cycle may be repeated > 50 days from start of previous cycle.  Incoming its in both received (PEDBy)  Incoming its in both regime in both regind in both regime in both regime in both reg

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

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