

Orange, CA

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Las Vegas, NV

P: (702) 790-4404 F: (702) 790-4406

Allen, TX

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Memphis, TN

P: (901) 560-3580 F: (901) 560-3581

Las Vegas, NV

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Carson City, NV

P: (702) 825-4900

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Burbank, CA

P: (818) 848-8112

F: (818) 848-8142

Las Vegas, NV

P: (702) 478-5133

F: (702) 478-5401

## Neurology Referral Form

### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_  
 Sex:  Femal  Male SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_ Language: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Wt: \_\_\_\_ Kg Lb Ht: \_\_\_\_ Cm In  
 Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Contact: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

### Prescriber Information

Prescriber Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
 If Shipping to prescriber:  Initial Fill  Always  Never  
 Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Fax: \_\_\_\_\_ Alt. Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

### INSURANCE INFORMATION (or attach copy of cards)

Medical Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Prescription Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Clinical Information

Access Type:  Peripheral  PICC  PORT  
 Has patient previously been on therapy before?  No  Yes/Last Infusion: \_\_\_\_\_  
 Previously Tried Treatments/Medications for The Condition: \_\_\_\_\_

### Ocrevus (ocrelizumab) 300mg/10mL Vial

Loading Doses  
 Infusion 1: 300mg intravenous in 250mL of 0.9% NS.  
 Infusion 2: (2 weeks later): 300mg intravenous in 250mL of 0.9% NS.  
 Start infusion at 30mL per hour. Increase by 30mL per hour every 30 minutes. Maximum rate: 180mL per hour.  
 Maintenance Dose  
 Infuse 600mg intravenous in 500mL of 0.9% NS every 6 months (from date of first loading dose).  
 Start infusion at 40mL per hour. Increase by 40mL per hour every 30 minutes. Maximum rate: 200mL per hour.  
 Refills: \_\_\_\_\_

### Soliris (eculizumab) 300mg/30mL Vial

Loading Doses  
 Infuse \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks for \_\_\_\_\_ weeks.  
 Maintenance Dose  
 Infuse \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks. Refills: \_\_\_\_\_

### Ultomiris (ravulizumab) 100mg/mL 1,100mg/11mL Vial OR 300mg/3mL Vial

Loading Doses  
 Infuse \_\_\_\_\_ mg IV on Day 1.  
 Maintenance Dose (2 Weeks Later)  
 Infuse \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks. Refills: \_\_\_\_\_

### Vyvgart (efgartigimod alfa-fcab) 400mg/20mL Vial injection

Loading Doses  
 OR  Infuse \_\_\_\_\_ mg/kg IV, 1 time weekly for 4 weeks. Over  
 Infuse \_\_\_\_\_ mg IV, 1 time weekly for 4 weeks. 1 Hour  
 Maintenance Dose  
 OR  Infuse \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks. Refills: \_\_\_\_\_  
 Infuse \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks.

**Tysabri ( natalizumab) 300mg/15 mL Vial**

- OR  Infuse 300mg IV every 4 weeks. Refills: \_\_\_\_\_  
 Infuse 300mg IV every \_\_\_\_\_ weeks.

**Hydration and Pre-Medications**

- Hydration: NaCl 0.9% 250mL to infuse at a rate of 250mL/hr IV before & after infusion as hydration is needed.
- Benadryl 25mg capsule: Take 1-2 caps by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.
- Benadryl 50mg ampule: Infuse \_\_\_\_\_mg slow IVP 30 minutes prior to infusion
- Tylenol 325mg: Take 1-2 tabs by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.  
Not to exceed total daily dose of 3000mg.
- Zofran 4mg ODT: Dissolve 1 tab on the tongue every 8 hours as needed for pre & post infusion for nausea and vomiting.
- Solu-Cortef: Infuse \_\_\_\_\_mg slow IVP 30 minutes prior to infusion
- Solu-Medrol: Infuse \_\_\_\_\_mg slow IVP 30 minutes prior to infusion

**Flushing Protocol**

- Sodium Chloride 0.9% 5-10 ml pre and post medications
- Heparin \_\_\_\_\_ Units/mL OR \_\_\_\_\_ mL as needed

**Anaphylaxis Protocol**

**MILD infusion reactions: (Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated)**  
Diphenhydramine 25mg caps #4 Sig: Take 1-2 capsules PO Q6H PRN for infusion reactions, NTE total daily dose of 400mg (16 caps/day).

**MODERATE infusion reactions: (Stop infusion, resume at 50% rate when symptoms resolve)**  
Diphenhydramine 50mg/ml vial #1 Sig: Inject 1ml (=50mg) IV by slow IV push over 3-5 mins PRN for anaphylaxis reaction.  
May repeat every 4 hrs, NTE 400mg/24hrs

**SEVERE ANAPHYLAXIS \*CALL 911\* (Stop infusion and remove tubing from access device to prevent further administration)**

1. Epinephrine 0.3mg Auto Injector #2 Sig: Remove cap then inject auto-injector intramuscularly in the thigh area and hold for 2 to 10 seconds as needed for anaphylaxis reaction, may administer through clothing if necessary. May repeat in 5-15-minutes.
2. Initiate 0.9% NaCl 500 mL IV x 1
3. Administer CPR if needed until EMS arrives

Ancillary Supplies : As needed for proper administration and disposal of medication

Skilled Nursing Visits: As needed for IV access, administration and proper clinical monitoring

Administration procedures to be followed per pharmacy protocol.

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): \_\_\_\_\_

Deliver to:  Home  Office  Infusion Suite  Other: \_\_\_\_\_

If shipped to prescriber's office or infusion clinic, prescriber accepts on behalf of patient for administration in office or infusion clinic.  
By signing this order, I, the prescriber, certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber's Signature \_\_\_\_\_

Date: \_\_/\_\_/\_\_

\* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.