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Neurology Misc Referral Form

Administer At: ☐ Patien's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name:_____

First Name:_____

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

2. Prescriber Information

Prescriber Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

NPI# _____ Office Contact:_____

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:_____ Height:_____ Weight:_____

Tried/Failed Meds and Therapies: _____

Diagnosis (ICD 10 Code):_____

4. Prescription Information ☐ DAW1- Dispense as written. Do not substitute for generic

Drug	Dose and Directions	Qty	Refill
☐ **Soliris**	**IV:** Induction: 900 mg once weekly for 4 doses; **Maintenance:** 1.2 g at week 5, then 1.2 g every 2 weeks thereafter	Available as: 300mg/30ml SDV Dispense #QS	
☐ **Ultomiris**	***Weight 40 kg to <60 kg:*** Loading dose: **IV:** 2,400 mg as a single dose. Maintenance dose: **IV:** 3,000 mg once every 8 weeks starting 2 weeks after the loading dose. ***Weight 60 kg to <100 kg:*** Loading dose: **IV:** 2,700 mg as a single dose. Maintenance dose: **IV:** 3,300 mg once every 8 weeks starting 2 weeks after the loading dose. ***Weight ≥100 kg:*** Loading dose: **IV:** 3,000 mg as a single dose. Maintenance dose: **IV:** 3,600 mg once every 8 weeks starting 2 weeks after the loading dose	Available as: 1100mg/11ml SDV 300mg/3ml SDV Dispense #QS	
☐ **Vyvgart**	IV: 10 mg/kg (maximum dose: 1.2 g) once weekly for 4 weeks Repeat subsequent treatment cycles after _____ days 10 mg/kg (maximum dose: 1.2 g) once weekly for 4 weeks may be administered based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle	Available as: 400mg/20ml SDV Dispense #QS	
Refill x12 months unless otherwise noted. Refill for _____			
Premedications ☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 25 mg PO ☐ Diphenhydramine 25 mg IV ☐ Methylprednisolone 125 mg IV ☐ Other: _____	Give premedications as directed 30 minutes prior to every infusion Other: _____	Quantity: As needed for each infusion	
☐ **Other**			

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____