

# NEUROLOGY INFUSION REFERRAL FORM



## PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT	
Primary Caregiver/Alt Contact Name (if applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

## PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title
Preferred Contact Method (check one)	<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	Referral Contact Email
Office Phone	Office Fax	
Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name / Specialty		
Prescriber State License #		DEA #
NPI #		Medicaid UPIN #

## INSURANCE INFORMATION

Insurance Provider	Plan ID #	
BIN#:	PCN#:	RX Group#:
Insured's Name	Relationship to Patient	

Eligible for Medicare (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list Medicare #
Prescription Card (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list carrier

**Please include a copy of the front and back of insurance card.**

## CLINICAL INFORMATION

Prescription Type	<input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment	Therapy Start Date
Sample/Starter Product Provided?	If yes, Provide Qty	Date Sample Provided
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)		
Therapies Tried and Failed (please list medications)		
Concurrent Medications		

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Ship to Address		
<input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)		
ICD-10 Codes	<input type="checkbox"/> D69.3 Immune Thrombocytopenic Purpura <input type="checkbox"/> G25.82 Stiff-man Syndrome <input type="checkbox"/> G35 Multiple Sclerosis <input type="checkbox"/> G60.3 Idiopathic Progressive Neuropathy <input type="checkbox"/> G61.0 Gullain-Barre Syndrome <input type="checkbox"/> G61.81 Chronic Inflammatory Demyelinating Polyneuritis <input type="checkbox"/> G62.89 Multifocal Motor Neuropathy <input type="checkbox"/> G70.00 Myasthenia Gravis without (acute) exacerbation <input type="checkbox"/> G70.01 Myasthenia Gravis with (acute) exacerbation <input type="checkbox"/> L10.0 Pemphigus Vulgaris <input type="checkbox"/> M33.20 Polymyositis organ involvement unspecified <input type="checkbox"/> M33.90 Dermatopolymyositis organ involvement unspecified <input type="checkbox"/> Other _____	

We accept Escribe and fax prescriptions.

Phone 855.896.9254 | Fax 855.370.0086

# PRESCRIPTIONS

Patient Last Name	Patient First Name	DOB
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## PRESCRIPTION INFORMATION

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Immune Globulin	<input type="checkbox"/> SC <input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> _____ grams <input type="checkbox"/> _____ grams	<input type="checkbox"/> 1 mg/kg/hr for first 30 minutes then increase every 30 minutes to a max rate of 6m/kg/hr not to exceed 300 ml/hr	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Lemtrada	<input type="checkbox"/> IV	<input type="checkbox"/> 12 mg/day	<input type="checkbox"/> Initial Dose - 12 mg/day over 4 hours for 5 consecutive days <input type="checkbox"/> Maintenance Dose - 12 mg/day IV over 4 hours for 3 consecutive dates 12 months after initial dose		<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Ocrevus	<input type="checkbox"/> IV	<input type="checkbox"/> 300 mg/10 mL vial	<input type="checkbox"/> Starter Dose - Infuse 300 mg iv over no less than 2.5 hours on day 1 and day 15 <input type="checkbox"/> Maintenance Dose - Infuse 600 mg iv over no less than 3.5 hours every 6 months		<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Tysabri	<input type="checkbox"/> IV	<input type="checkbox"/> 300 mg in 100 mLs NaCl 0.9%	<input type="checkbox"/> Infuse over 60 minutes every 6 months		<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Normal Saline <input type="checkbox"/> D5W	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Heparin 10 units/mL <input type="checkbox"/> Heparin 100 units/mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> PRN Allergic Reaction: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg <input type="checkbox"/> 1 gm <input type="checkbox"/> _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30kg/>66lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Other:	<input type="checkbox"/> _____				
<input type="checkbox"/> Vascular Access Method	<input type="checkbox"/> peripheral <input type="checkbox"/> central <input type="checkbox"/> other: _____				

**Total RXs** \_\_\_\_\_

**Lab Orders** \_\_\_\_\_  
 Skilled nursing visits as needed to establish venous access administer medication and assess general status and response to therapy. Dispense 1 month of drug, flushes, needles, syringes, ancillary supplies and medical equipment necessary to establish access and administer medication. Prescription to include all necessary ancillary supplies (needle, syringes, etc). If shipped to physician's office, physician accepts on behalf of patient for administration in office.

**Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted support program.**

_____ Patient Signature	____ / ____ / ____ Date	_____ Account Manager
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**Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting.)**

_____ Prescriber Signature	____ / ____ / ____ Date
_____ Supervising Physician Signature (Dispense as Written)	____ / ____ / ____ Date

**\*\*The information contained in this document will become a legal prescription. Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.**

*Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.*