NEUROLOGY INFUSION REFERRAL FORM

PHONE 855.896.9254 | **FAX** 855.370.0086

AMBER SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax	
Referral Contact Email	Office Phone	Office Fax	
Practice / Facility Name	Prescriber Name / Specialty		
Address	City	State	ZIP

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

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			Therapy Start Date	
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Therapies Tried and Failed (please list medications)				
Other/Concomitant Medications (please list)				
Allergies ☐ NKDA ☐ Drug Allergies (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				

ICD-10 Code

- ☐ D69.3 Immune Thrombocytopenic Purpura
- ☐ G25.82 Stiff-man Sydrome
- ☐ G35 Multiple Sclerosis
- ☐ G60.3 Idiopathic Progressive Neuropathy
- ☐ G61.0 Gullain-Barre Syndrome
- ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuritis
- ☐ G62.89 Multifocal Motor Neuropathy
- ☐ G70.00 Myasthenia Gravis without (acute) exacerbation
- ☐ G70.01 Mysthenia Gravis with (acute) exacerbation
- ☐ L10.0 Pemphigus Vulgaris
- ☐ M33.20 Polymyositis organ involvement unspecified
- ☐ M33.90 Dermatopolymyositis organ involvement unspecified
- ☐ Other _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Briumvi	☐ IV	☐ 150 mg	☐ Starting Dose - 150 mg on day 1, followed by 450 mg once 2 weeks later ☐ Maintenance Dose - 450 mg once every 24	3 Vials	0
☐ Immune Globulin	☐ SC ☐ IV ☐ IM	☐ _____ grams ☐ _____ grams	☐ 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	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Lemtrada	☐ IV	☐ 12 mg/day	☐ Initial Dose – 12 mg/day over 4 hours for 5 consecutive days ☐ Maintenance Dose – 12 mg/day IV over 4 hours for 3 consecutive dates 12 months after initial dose		☐ 1 year ☐ _____
☐ Ocrevus	☐ IV	☐ 300 mg/10 mL vial	☐ Starter Dose – Infuse 300 mg iv over no less than 2.5 hours on day 1 and day 15 ☐ Maintenance Dose – Infuse 600 mg iv over no less than 3.5 hours every 6 months		☐ 1 year ☐ _____
☐ Vascular Access Method	☐ peripheral	☐ central	☐ other: _____		
☐ Normal Saline ☐ D5W	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Diphenhydramine	☐ PO ☐ IV ☐ IM	☐ 25 mg ☐ 50 mg ☐ _____	☐ After infusion ☐ PRN Allergic Reaction: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 500 mg ☐ 650 mg ☐ 1 gm ☐ _____	☐ Pre-Med: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000, 0.3 mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	☐ 1 year ☐ _____
☐ Other:	☐ _____				

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ NPI # _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

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