US infusions

NEUROLOGY ORDER SET

NEUROLOGY ORDERS:

Patient Name: _____ DOB: _____ Phone: _____
☐ New to therapy ☐ Continuing therapy: next treatment date: _____.

MEDICAL INFORMATION:

☐ G43.911 – Acute Migraine
☐ G61.81 - Chronic Inflammatory Demyelinating Polyneuropathy
☐ G61.0 - Guillain-Barre
☐ E85.82 – hATTR Amyloidosis
☐ G43.909 – Migraine
☐ G61.82 - Multifocal Motor Neuropathy
☐ G35 – Multiple Sclerosis
☐ G70.00 – Myasthenia Gravis
☐ G36.0 – Neuromyelitis Optica Spectrum Disorder w/+AQP4 Antibodies
☐ E74.02 – Pompe Disease
☐ Other: _____
☐ G70.01- Myasthenia Gravis with exacerbation

THERAPY ORDERS:

☐ ***Amvuttra:** Dose: ☐ 25mg subcutaneously every 3 months x1 year

☐ ***Briumvi:** Initial Dose: ☐ 150mg IV x 1, then 450mg IV 2 weeks later, followed by 450mg IV at 24 weeks after 1st infusion.
Maintenance Dose: ☐ 450mg IV every 24 weeks x1 year

☐ ***IVIG**: Dose: ☐ _____mg/kg **OR** ☐ _____gm/kg IV x_____ day(s) **OR** ☐ divided over _____ day(s)
Frequency: ☐ Every _____ weeks x1 year **OR** Other _____

☐ **Lumizyme:** Dose: ☐ 20mg/kg IV every 2 weeks x1 year

☐ **Nexviazyme:** Dose: ☐ 20mg/kg IV every 2 weeks x1 year

☐ ***Ocrevus:** Dose: ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year ☐ 600mg IV every 6 months x1 year

☐ **Rystiggo:** Dose: ☐ 420 mg (<50kg) ☐ 560mg (50kg to <100kg) ☐ 840mg (<100kg)
Frequency: every 6 weeks x 6 weeks. Repeat for cycles (after 63 days from previous cycle.

☐ **Soliris:** Initial Dose with Maintenance: ☐ 900mg IV weekly for the first 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg every 2 weeks thereafter x1 year
Maintenance Dose: ☐ 1200mg IV every 2 weeks x1 year

☐ **Solu-Cortef OR** ☐ **Solu-Medrol:** Dose: ☐ 1gm IV daily x _____ days

☐ **Tysabri:** Dose: ☐ 300mg IV every 4 weeks (after registering patient with TOUCH)

☐ **Ultomiris:** Initial Dose: ☐ 2400mg (40-59kg) IV ☐ 2700mg (60-99kg) IV ☐ 3000mg (100kg+) IV
Frequency: ☐ once, followed two weeks later by maintenance dose
Maintenance Dose: ☐ 3000mg (40-59kg) IV ☐ 3300mg (60-99kg) IV ☐ 3600mg (100kg+) IV
Frequency: ☐ every 8 weeks x1 year

☐ **Vyepti:** Dose: ☐ 100mg IV every 3 months x1 year **OR** ☐ 300mg IV every 3 months x1 year

☐ **Vyvgart:** Dose: ☐ 10mg/kg IV once weekly for 4 weeks (<120kg) ☐ 1200mg IV weekly for 4 weeks (≥120kg)
☐ Repeat cycle >50 days from the start of the previous cycle

☐ **Vyvgart Hytrulo:** gMG Dose: ☐ 1008mg/11200 units subcutaneously weekly for 4 weeks
☐ Repeat cycle >50 days from the start of the previous cycle
☐ CIDP:☐ 1008mg/11200 units subcutaneously weekly x 1 year

***See opposite page for required pre-screening or pre-medication orders**

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

US infusions

NEUROLOGY ORDER SET

NEUROLOGY ORDERS:

Patient Name: _____ DOB: _____ Phone: _____

PREMEDICATION ORDERS:

☐ Cetirizine 10mg ☐ PO ☐ IV
☐ Depacon ☐ 500mg IV ☐ 750mg IV
☐ Diphenhydramine 25mg ☐ PO ☐ IV
☐ DHE 45 ☐ 0.5mg ☐ 1mg IV in 100mL NS
☐ Loratadine 10mg PO
☐ Magnesium Sulfate 1gm
☐ Pepcid IV 20mg IVP
☐ Reglan 10mg IV
☐ Solu-Medrol ☐ 125mg IVP ☐ ___mg IVP
☐ Toradol 30mg IVP
☐ Tylenol 1000mg PO
☐ Zofran ☐ 4mg IVP ☐ 8mg IVP

MEDICAL INFORMATION:

Patient weight: _____lbs. Allergies: _____
Lab orders: _____ Frequency: ☐ Each infusion ☐ Other: _____

THERAPIES TRIED AND FAILED, INTOLERANCES, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY:

_____

_____

REQUIRED PRE-SCREENING:

☐ **Briumvi:** ☐ Hepatitis B antigen *and* core total ☐ MRI documentation ☐ Serum immunoglobulins
☐ **Ocrevus:** ☐ Hepatitis B antigen *and* core total ☐ MRI documentation ☐ Serum immunoglobulins
☐ **Rystiggo:** ☐ AChR antibody OR ☐ MuSK antibody
☐ **Soliris:** ☐ Meningococcal vaccinations – both Men B and MenACWY
☐ **Tysabri:** ☐ JCV antibody ☐ MRI documentation
☐ **Ultomiris:** ☐ AChR antibody OR ☐ MuSK antibody ☐ Meningococcal vaccinations(both Men B, MenACWY)
☐ **Vyvgart:** ☐ AChR antibody and ☐MG-ADL score, MDFA II, III or IV ☐ *Serum IgG (BCBS FEP)*

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics
☐ Front/back of all insurance cards
☐ Current medication list
☐ Labs and/or test results/EMG
☐ Include clinical note supporting the above diagnoses. Strength/ weakness documentation.

☐ Include supporting clinical notes detailing contraindications, intolerance, or failed trials of conventional therapy or biologic.
☐ *If applicable* - Last known biological therapy and last date.

☐ *If switching to biologic therapy* - please perform a wash-out period of _____ weeks prior to starting ordered biologic.

REFERRING PROVIDER INFORMATION:

Provider name: _____ Signature:_____ Date:_____

NPI: _____ Phone: _____ Fax: _____

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606