

PATIENT INFORMATION			
PATIENT NAME		DATE OF BIRTH	PHONE
WEIGHT — required for dosing		ALLERGIES	PATIENT STATUS ☐ New ☐ Continuing
REFERRING PRESCRIBER & INSURANCE			
PRESCRIBER NAME		NPI #	PHONE
PRIMARY INSURANCE		POLICY #	GROUP #
			NEXT TREATMENT DATE
DIAGNOSIS ICD-10 required — check all that apply			
MULTIPLE SCLEROSIS / DEMYELINATING ☐ G35 Multiple sclerosis ☐ G36.0 NMOSD ☐ G37.3 Transverse myelitis ALZHEIMER'S / COGNITIVE ☐ G30.9 Alzheimer's, unspec. ☐ G30.0 Early onset ☐ G30.1 Late onset ☐ G31.84 Mild cognitive impairment ☐ F02.80 / F02.81 Dementia w/o or w/ behavioral disturbance NEUROPATHY ☐ G61.81 CIDP ☐ G61.0 Guillain-Barré ☐ G61.82 Multifocal motor neuropathy ☐ E85.1 Hereditary ATTR amyloidosis with polyneuropathy		MYASTHENIA GRAVIS / NEUROMUSCULAR ☐ G70.00 MG w/o exacerbation ☐ G70.01 MG w/ exacerbation ☐ G73.1 Lambert-Eaton MIGRAINE ☐ G43.709 Chronic, not intractable ☐ G43.719 Chronic, intractable ☐ G43.009 Without aura ☐ G43.109 With aura ☐ G43.911 Status migrainosus IMMUNE, METABOLIC & OTHER ☐ D59.5 PNH ☐ D59.3- HUS ☐ E74.02 Pompe ☐ G25.82 Stiff person ☐ D80.1 Hypogammaglobulinemia ☐ D83.9 CVID ☐ M33.90 Dermatomyositis	
OTHER ICD-10		PRIMARY DIAGNOSIS DESCRIPTION	
THERAPY ORDER by disease process — complete only the product being ordered • refills × 1 year unless noted			
MULTIPLE SCLEROSIS & DEMYELINATING DISEASE — pre-med: Solu-Medrol 100 mg IV + diphenhydramine 25 mg PO/IV 30 min before (Briumvi, Ocrevus)			
Briumvi ublituximab	☐ 150 mg IV ×1, then 450 mg IV at week 2, then 450 mg IV every 24 weeks ☐ 450 mg IV every 24 weeks		
Ocrevus ocrelizumab	☐ 300 mg IV at 0 and 2 weeks, then 600 mg IV every 6 months ☐ 600 mg IV every 6 months		
Ocrevus Zunovo ocrelizumab/hyaluronidase	☐ 920 mg / 23,000 units SC every 6 months pre-med: dexamethasone 20 mg PO + cetirizine 10 mg PO 30 min prior		
Tysabri natalizumab	☐ 300 mg IV every 4 weeks		
MYASTHENIA GRAVIS & NEUROMUSCULAR			
Imaavy nipocalimab	☐ 30 mg/kg IV ×1, then 15 mg/kg IV at week 2, then 15 mg/kg IV every 2 weeks ☐ 15 mg/kg IV every 2 weeks		
Rystiggo rozanolixizumab	☐ <50 kg: 420 mg ☐ 50–<100 kg: 560 mg ☐ ≥100 kg: 840 mg SC weekly ×6 (= 1 cycle) ☐ ____ cycle(s), ____ wks between		
Soliris eculizumab	☐ 900 mg IV weekly ×4, then 1,200 mg 1 week later, then 1,200 mg IV every 2 weeks ☐ 1,200 mg IV every 2 weeks		
Ultomiris ravulizumab	Load ☐ 2,400 (40–59 kg) ☐ 2,700 (60–99 kg) ☐ 3,000 mg (100 kg+) → maintenance ☐ 3,000 ☐ 3,300 ☐ 3,600 mg IV every 8 weeks		
Vyvgart efgartigimod alfa	☐ 10 mg/kg IV weekly ×4 (<120 kg) ☐ 1,200 mg IV weekly ×4 (≥120 kg) ☐ ____ cycle(s), ____ wks between cycles		
Vyvgart Hytrulo efgartigimod/hyaluronidase	☐ 1,008 mg / 11,200 units SC — ☐ weekly ×4 weeks ☐ every week ☐ ____ refill(s) ☐ none		
ALZHEIMER'S DISEASE — ANTI-AMYLOID			
Leqembi lecanemab	☐ 10 mg/kg IV every 2 weeks ☐ Maintenance: 10 mg/kg IV every 4 weeks ☐ Other: _____		
Kisunla donanemab	☐ 700 mg IV every 4 weeks ×3 doses, then 1,400 mg IV every 4 weeks ☐ Titration per current label ☐ Other: _____ Required for both: ☐ APOE ε4 genotype ☐ baseline MRI within 12 months ☐ MRI monitoring per label ☐ anticoagulant / antiplatelet status reviewed		
MIGRAINE			
Vyepthi eptinezumab	☐ 100 mg IV every 3 months ☐ 300 mg IV every 3 months		
Migraine infusion select components	☐ 0.9% NS 1,000 mL IV ☐ Ketorolac ☐ 15 mg ☐ 30 mg IV ☐ Metoclopramide 10 mg IV ☐ Prochlorperazine 10 mg IV ☐ Diphenhydramine 25 mg IV ☐ Dexamethasone 10 mg IV ☐ Magnesium sulfate ☐ 1 g ☐ 2 g IV ☐ Valproate sodium ____ mg IV ☐ Sumatriptan 6 mg SC ☐ Dihydroergotamine 1 mg IV ☐ Other: _____ Frequency: ☐ single visit ☐ daily × ____ days ☐ PRN, max ____ /month		
NEUROPATHY, IMMUNE & OTHER			
IVlg immune globulin IV	____ mg/kg OR ____ gm/kg IV over ____ day(s) • every ____ weeks OR ☐ one-time • Brand: _____ (LIVbetter chooses if blank)		
Amvuttra vutrisiran	☐ 25 mg subcutaneously every 3 months		
Nexvazyme avalglucosidase alfa	☐ 20 mg/kg IV every 2 weeks		
Solu-Medrol methylprednisolone	1 gm IV daily × ____ day(s) (no refills)		
Not listed	☐ Product: _____ Dose / route / frequency: _____		
PRE-MEDICATION, LABS & REQUIRED DOCUMENTATION			
Pre-meds	APAP ☐ 1,000 ☐ 500 mg PO Antihistamine ☐ Diphenhydramine 25 mg PO ☐ Loratadine 10 mg ☐ Cetirizine 10 mg ☐ PO ☐ IVP ☐ Solu-Medrol ____ mg ☐ Solu-Cortef ____ mg IVP		
Labs	Orders: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring provider		
Attach	☐ Signed order ☐ Demographics + insurance ☐ Medication list ☐ Clinical notes (H&P) incl. tried/failed therapy ☐ JC virus Ab (Tysabri) ☐ AChR/MuSK Ab (Rystiggo, Imaavy, Vyvgart, Ultomiris) ☐ HBsAg + HBcAb total & serum IgG (Ocrevus, Brriumvi) ☐ MRI (Tysabri, Ocrevus, Brriumvi, Leqembi, Kisunla) ☐ Men B + Men ACWY vaccination (Soliris, Ultomiris) ☐ Prior therapy failed: _____		
PRESCRIBER SIGNATURE required — we cannot schedule without it			
By signing, you authorize LIVbetter Infusions to act as your prior authorization and specialty pharmacy designated agent with insurance companies and to select the site of care.			
PRESCRIBER SIGNATURE X	DATE	DISPENSE AS WRITTEN ☐ Yes	