LIVbetter INFUSIONS

NEUROLOGY REFERRAL & ORDER SET

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	PHONE

WEIGHT — required for dosing	ALLERGIES	PATIENT STATUS
		☐ New ☐ Continuing

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

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 syndrome

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 → 450 mg at week 2 → 450 mg every 24 weeks ☐ 450 mg IV every 24 weeks
Ocrevus *ocrelizumab*	☐ 300 mg IV at 0 and 2 weeks → 600 mg 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 → 15 mg/kg at week 2 → 15 mg/kg every 2 weeks ☐ 15 mg/kg IV every 2 weeks
Rystiggo *rozanolixizumab*	☐ <50 kg: 420 ☐ 50–<100 kg: 560 ☐ ≥100 kg: 840 mg SC weekly ×6 = 1 cycle ☐ ___ cycle(s)
Soliris *eculizumab*	☐ 900 mg IV weekly ×4 → 1,200 mg 1 week later → 1,200 mg every 2 weeks ☐ 1,200 mg IV q2 weeks
Ultomiris *ravulizumab*	Load ☐ 2,400 (40–59 kg) ☐ 2,700 (60–99 kg) ☐ 3,000 mg (100 kg+) → every 8 wks ☐ 3,000 ☐ 3,300 ☐ 3,600 mg
Vyvgart *efgartigimod alfa*	☐ 10 mg/kg IV weekly ×4 (<120 kg) ☐ 1,200 mg IV weekly ×4 (≥120 kg) ☐ ___ cycle(s), ___ wks apart
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*	☐ Titration: **350 mg → 700 mg → 1,050 mg → 1,400 mg IV, every 4 weeks** (current label) ☐ 1,400 mg IV every 4 weeks — already titrated ☐ Other: _____ **Required for both:** ☐ APOE ε4 genotype ☐ baseline MRI <12 months ☐ MRI monitoring per label ☐ anticoagulant/antiplatelet reviewed
MIGRAINE	
Vyepti *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 ___ mg IV ☐ Sumatriptan 6 mg SC Frequency: ☐ single visit ☐ daily × ___ days ☐ PRN, max ___ per month
NEUROPATHY, IMMUNE & OTHER	
IVIg *immune globulin IV*	_____ mg/kg OR _____ gm/kg IV over ____ day(s) · every ____ wks OR ☐ one-time · Brand: _____
Amvuttra *vutrisiran*	☐ 25 mg subcutaneously every 3 months
Nexviazyme *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 IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____
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) ☐ HBsAg + HBcAb + serum IgG (Ocrevus, Briumvi) ☐ MRI (Tysabri, Ocrevus, Briumvi, Leqembi, Kisunla) ☐ Men B + 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	DATE	DISPENSE AS WRITTEN
X		☐ Yes