metroplex vitalcare
INFUSION SERVICES

Infusion Pharmacy Order Form
NEUROLOGY

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PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached ☐ Last MRI documentation attached

☐ Patient's TOUCH authorization (only for Tysabri orders) ☐ Hepatitis B antigen and Hepatitis B Core total antibody required (only for Ocrevus orders) ☐ Confirmed Presence of amyloid pathology (CSF or PET scan) attached (only for Aduhelm orders)

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

INFUSION ORDERS

☐ Alzheimer's Disease
ICD-10: _____

Administer Aduhelm IV every 4 weeks as follows (Select One):
☐ Initial start w/ maintenance dosing:
- 1mg/kg for infusion 1 and 2
- 3mg/kg for infusion 3 and 4
- 6mg/kg for infusion 5 and 6
- 10 mg/kg for infusion 7 and beyond

☐ Maintenance doing only: 10mg/kg

☐ Migraines
ICD-10: _____

Pre-Medication: ☐ Zofran 4mg slow IVP ☐ Zofran 8mg IVP ☐ Pepcid IV 20mg IVP ☐ Toradol 30mg IVP ☐ Solu-Medrol 125mg IVP ☐ Reglan 10mg IV/100mL NS over 20 minutes ☐ Benadryl 25mg IV

Protocol: ☐ Depacon ☐ 500mg ☐ 750mg IV in 250mL NS ☐ Magnesium Sulfate 1gm IV in 250mL ☐ DHE 45 ☐ 0.5mg ☐ 1mg IV in 100mL NS *(must premed for nausea)*

Standing PRN Order: ☐ 1 month ☐ 2 months ☐ 3 months Repeat regimen daily for _____ days

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☐ Migraines
ICD-10: _____

Vyepti: ☐ 100mg IV every 3 months ☐ 300mg IV every 3 months

☐ Multiple Sclerosis Exacerbation
ICD-10: _____

☐ Solu-Medrol 1gm IV daily x _____ days
☐ Solu-Cortef 1gm IV daily x _____ days

☐ Multiple Sclerosis
ICD-10: _____

☐ Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH)
Pre-medication protocol: Tylenol 1000mg PO and Benadryl 25mg PO

☐ Ocrevus ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months ☐ 600mg IV every 6 months
Pre-Medication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion

IVIG ORDERS

Diagnosis: _____ ICD-10: _____ IVIG Brand: _____

IVIG Orders: _____ mg/kg OR _____ gm/kg IV divided over _____ day(s)

Frequency: Every _____ weeks **OR** _____ one time dose only

Protocol Pre-Medication Orders: Tylenol 1000mg PO

please choose one antihistamine: ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg - IVP

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Metroplex Vital Care and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____