Neurology Therapies

Referring Physician Orders Rev. 3/2025

Please fax completed referral form & all required documents to 208-595-4427

INFUSED HEALTH
MEDICAL + KETAMINE + HYDRATION IV THERAPY

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Amyotrophic Lateral Sclerosis (ALS), G12.21
☐ Multifocal Motor Neuropathy (MMN), G61.82
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), G61.81
☐ Guillain-Barre Syndrome (GBS), G61.0
☐ Other: _____, ICD10 _____
☐ Multiple Sclerosis (MS), G35
☐ Myasthenia Gravis without (acute) exacerbation, G70.00
☐ Myasthenia Gravis with (acute) exacerbation, G70.01
☐ Migraine, unspecified, G43.9

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Briumvi™ (ublituximab)	☐ **FIRST DOSE:** 150mg ☐ **SECOND and SUBSEQUENT DOSES:** 450mg	☐ **FIRST DOSE:** Infuse IV over 4 hours x 1 dose. ☐ **SECOND DOSE** (2 weeks after 1st Dose)**:** Infuse IV over 1 hour x 1 dose. ☐ **SUBSEQUENT DOSES:** Infuse IV over 1 hour every 6 months x 1 year. *Observe patient for 1 hour after completion of first two infusions.*
IVIG ☐ Bivigam 10% ☐ Octagam 5% ☐ Panzyga 10% ☐ Octagam 10% ☐ Other Brand and Conc: _____	☐ **0.4 gm/kg:** _____ gm ☐ **1 gm/kg:** _____ gm ☐ **2 gm/kg:** _____ gm ☐ **Other:** _____ gm (total) * Specify total dose in grams per infusion and order to the nearest 5 grams.	☐ **INITIAL:** Infuse IV daily x ____ days. ☐ **MAINTENANCE:** Infuse IV daily x ____ days every ____ weeks x 1 year. ☐ **OTHER:** _____ Ramp up infusion over 90 minutes to maximum rate of 150 mL/hr (10% IVIG) or 250 mL/hr (5% IVIG), or as tolerated, then ramp down over 1 minute.
Ocrevus® (ocrelizumab)	**INITIAL:** 300mg **MAINTENANCE:** 600mg	☐ **INITIAL:** Infuse 300mg IV over 2.5 hours at Weeks 0 and 2. ☐ **MAINTENANCE:** Infuse 600mg IV over 3.5 hours every 6 months x 1 year. ☐ **MAINTENANCE:** Infuse 600mg IV over 2 hours every 6 months x 1 year. *Observe patient for 1 hour after completion of infusion.*
Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq)	23mL (ocrelizumab 920 mg and hyaluronidase 23,000 units)	☐ Infuse SC in the abdomen over 10 minutes every 6 months x 1 year *Observe patient for 1 hour after initial dose and for 15 minutes for all subsequent doses.
Soliris® (eculizumab)	**INITIAL:** 900mg **MAINTENANCE:** 1200mg	☐ **INITIAL:** Infuse 900mg IV over 35 minutes weekly x 4 doses. ☐ **MAINTENANCE:** Infuse 1200mg IV over 35 minutes every 2 weeks x 1 year. *Observe patient for 1 hour after completion of infusion.*
Rystiggo® (rozanoliximab)	☐ <50kg: 420mg ☐ 50kg to <100kg: 560mg ☐ ≥100kg: 840mg	☐ Infuse SC over 9-18 minutes (20 mL/hr) once weekly x 6 doses. *Observe patient for 15 minutes after completion of infusion.* ☐ Repeat treatment cycle every ____ weeks x 1 year. (No sooner than 63 days from the start of the previous treatment cycle.)
Tysabri® (natalizumab) ☐ Patient enrolled in TOUCH Prescribing Program	300mg	☐ Infuse IV over 1 hour every 4 weeks x _____ months. *Observe patient for 1 hour after completion of infusion.* ☐ If no hypersensitivity reaction observed with first 12 infusions, then post-infusion observations as directed by MD.
Vyepti® (eptinezumab)	☐ 100mg ☐ 300mg	☐ Infuse IV over 30 minutes once every 3 months x 1 year.
Vyvgart® (efgartigimod alfa)	☐ <120kg: _____ mg (10mg/kg) ☐ ≥120kg: 1200 mg	☐ Infuse IV over 1 hour once weekly x 4 doses. *Observe patient for 1 hour after completion of infusion.* ☐ Repeat treatment cycle every ____ weeks x 1 year. (No sooner than 50 days from the start of the previous treatment cycle.)
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-gyfc))	5.6mL (efgartigimod alfa 1,008mg and hyaluronidase-gyfc 11,200 units)	☐ Inject SC over 30-90 seconds once weekly x 4 doses. *Observe patient for 30 minutes after completion of injection.* ☐ Repeat treatment cycle every ____ weeks x 1 year. (No sooner than 50 days from the start of the previous treatment cycle.)

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by**:** ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV
☐ Other: _____

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Patient Name: _____ DOB: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Test Results (required)

- Hepatitis B Screening for Ocrevus (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by: ☐ Infusion Center ☐ Referring Physician
- Meningococcal vaccination for Soliris (must be completed at least 2 weeks prior to starting therapy)

Diagnostic Test Results (please attach copy for all items checked)

For ALS:

☐ ALS Functional Rating Scale-revised (ALSFRS-r)
☐ Pulmonary function test

For MMN

☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ anti-GM1 antibodies
☐ Lumbar puncture test

For CIDP

☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ Lumbar puncture test
☐ Nerve biopsy report
☐ Neurological Rankin Scale Score

For Myasthenia Gravis

☐ Acetylcholine receptor (AChR) antibodies
☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation

Prior Failed Therapies (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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