

Neurology Therapies

Referring Physician Orders Rev. 01/2025ss

Contact us with questions at: 804-442-3558 or email: referrals@theinfusionsolution.com

Please fax completed referral form & all required documents to 804-554-5848



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**
- | | |
|---|---|
| <input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), G61.81 | <input type="checkbox"/> Myasthenia Gravis without (acute) exacerbation, G70.00 |
| <input type="checkbox"/> Guillain-Barre Syndrome (GBS), G61.0 | <input type="checkbox"/> Myasthenia Gravis with (acute) exacerbation, G70.01 |
| <input type="checkbox"/> Multifocal Motor Neuropathy (MMN), G61.82 | <input type="checkbox"/> Migraine, unspecified, G43.9 |
| <input type="checkbox"/> Multiple Sclerosis (MS), G35 | <input type="checkbox"/> Other: _____, ICD10 _____ |

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Briumvi™ (ublituximab)	<input type="checkbox"/> FIRST DOSE: 150mg <input type="checkbox"/> SECOND and SUBSEQUENT DOSES: 450mg	<input type="checkbox"/> FIRST DOSE: Infuse IV over 4 hours x 1 dose. <input type="checkbox"/> SECOND DOSE (2 weeks after 1 st Dose): Infuse IV over 1 hour x 1 dose. <input type="checkbox"/> 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 <input type="checkbox"/> Bivigam 10% <input type="checkbox"/> Octagam 5% <input type="checkbox"/> Octagam 10% <input type="checkbox"/> Other Brand and Conc: _____	<input type="checkbox"/> 0.4 gm/kg: _____ gm <input type="checkbox"/> 1 gm/kg: _____ gm <input type="checkbox"/> 2 gm/kg: _____ gm <input type="checkbox"/> Other: _____ gm (total) * Specify total dose in grams per infusion and order to the nearest 5 grams.	<input type="checkbox"/> INITIAL: Infuse IV daily x _____ days. <input type="checkbox"/> MAINTENANCE: Infuse IV daily x _____ days every _____ weeks x 1 year. <input type="checkbox"/> 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	<input type="checkbox"/> INITIAL: Infuse 300mg IV over 2.5 hours at Weeks 0 and 2. <input type="checkbox"/> MAINTENANCE: Infuse 600mg IV over 3.5 hours every 6 months x 1 year. <input type="checkbox"/> MAINTENANCE: Infuse 600mg IV over 2 hours every 6 months x 1 year. *Observe patient for 1 hour after completion of infusion.*
Rystiggo® (rozanoliximab)	<input type="checkbox"/> <50kg: 420mg <input type="checkbox"/> 50kg to <100kg: 560mg <input type="checkbox"/> ≥100kg: 840mg	<input type="checkbox"/> Infuse SC over 9-18 minutes (20 mL/hr) once weekly x 6 doses. *Observe patient for 15 minutes after completion of infusion.* <input type="checkbox"/> Repeat treatment cycle every _____ weeks x 1 year. (No sooner than 63 days from the start of the previous treatment cycle.)
Tysabri® (natalizumab) <input type="checkbox"/> Patient enrolled in TOUCH Prescribing Program	300mg	<input type="checkbox"/> Infuse IV over 1 hour every 4 weeks x _____ months. *Observe patient for 1 hour after completion of infusion.* <input type="checkbox"/> If no hypersensitivity reaction observed with first 12 infusions, then post-infusion observations as directed by MD.
Vyepti® (eptinezumab)	<input type="checkbox"/> 100mg <input type="checkbox"/> 300mg	<input type="checkbox"/> Infuse IV over 30 minutes once every 3 months x 1 year.
Vyvgart® (efgartigimod alfa)	<input type="checkbox"/> <120kg: _____ mg (10mg/kg) <input type="checkbox"/> ≥120kg: 1200 mg	<input type="checkbox"/> Infuse IV over 1 hour once weekly x 4 doses. *Observe patient for 1 hour after completion of infusion.* <input type="checkbox"/> 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)	<input type="checkbox"/> Inject SC over 30-90 seconds once weekly x 4 doses. *Observe patient for 30 minutes after completion of injection.* <input type="checkbox"/> Repeat treatment cycle every _____ weeks x 1 year. (No sooner than 50 days from the start of the previous treatment cycle.)

**For drug doses that are calculated based on patient weight, a new order will be requested for weight changes of +/- 5 kgs.

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
☐ Other: _____
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

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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 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: _____

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