ALLIED INFUSION SERVICES

Neurology Infusion Orders

Phone: 713-222-2364 or 1-888-538-0060
Fax: 832-698-3961

Patient Information

Name: _____
DOB: _____
Address: _____
City: _____ State: _____
Zip: _____ Weight: _____
Phone: _____
Allergies: _____

Prescriber Information

Prescriber Name: _____
NPI: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____

Diagnosis (please provide ICD-10 code in space provided):

_____ Multiple Sclerosis _____ Relapsing and Remitting _____ Primary Progressive
_____ Migraine _____ Myasthenia Gravis Other: _____

Nursing Orders: Hold infusion and notify provider for:

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles. If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Premedications:

☐ Tylenol 650mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol IV 40mg, 125mg or ____ mg
☐ Other: _____ IV or PO

Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability

☐ Tysabri 300 MG IV	☐ Every 28 days Mixed in 100 mL 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
☐ Ocrevus IV	☐ 300 MG ☐ 600 MG ☐ Ocrevus 300mg Week 0,2 then 600 mg every 6 months ☐ Ocrevus 600mg every 6 months Mix 300 MG in 250 mL 0.9% sodium chloride Mix 600 MG in 500 mL 0.9% sodium chloride Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
IVIG IV ☐ Gammagard ☐ Gamunex-C ☐ Other	_____gms ☐ Every _____ weeks ☐ 2 consecutive days every _____ weeks ☐ _____ _____ Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
☐ Vyepti IV	☐ Vyepti 100mg every 3 months ☐ _____ _____
☐ Vyvgart IV	☐ Infuse IV 10 mg/kg (Dose = _____ mg) weekly for 4 weeks (1 cycle). Infuse over 1 hour. ☐ Infuse _____ mg/kg (Dose = _____ mg) weekly for ____ weeks. (1 cycle). Infuse over _____ hour(s) Subsequent treatment cycles must be based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.

Prescriber Name (Please print): _____
Prescriber Signature: _____ Date: _____

Please include a copy of the latest insurance information as well as all applicable clinical notes.

Email to: orders@alliedinfusion.com Fax to: 832-698-3961

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.