



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):
<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Relapsing and Remitting <input type="checkbox"/> Primary Progressive <input type="checkbox"/> Migraine <input type="checkbox"/> 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:	
<input type="checkbox"/> Tylenol 650mg PO <input type="checkbox"/> Benadryl 25mg IV or PO <input type="checkbox"/> Solu-Medrol IV 40mg, 125mg or ____ mg <input type="checkbox"/> 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	
<input type="checkbox"/> Tysabri 300 MG IV	<input type="checkbox"/> 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).
<input type="checkbox"/> Ocrevus IV	<input type="checkbox"/> 300 MG <input type="checkbox"/> 600 MG <input type="checkbox"/> Ocrevus 300mg Week 0,2 then 600 mg every 6 months <input type="checkbox"/> 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 0.2 micron).
IVIG IV <input type="checkbox"/> Gammagard <input type="checkbox"/> Gamunex-C <input type="checkbox"/> Other	_____ gms <input type="checkbox"/> Every _____ weeks <input type="checkbox"/> 2 consecutive days every _____ weeks <input type="checkbox"/> _____ Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
<input type="checkbox"/> Vyapti IV	<input type="checkbox"/> Vyapti 100mg every 3 months <input type="checkbox"/> _____ Mixed in 100 ml 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic filter (pore size 0.2 micron).
<input type="checkbox"/> Vyvgart IV	<input type="checkbox"/> Infuse IV 10 mg/kg (Dose = _____ mg) weekly for 4 weeks (1 cycle). Infuse over 1 hour. Mixed in 100 ml 0.9% sodium chloride. <input type="checkbox"/> Infuse _____ mg/kg (Dose = _____ mg) weekly for _____ weeks. (1 cycle). Infuse over _____ hour(s). Mixed in 100 ml 0.9% sodium chloride. Subsequent treatment cycles must be based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle. Use in-line, sterile, non-pyrogenic filter (pore size 0.2 micron).

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