vitalcare® INFUSION SERVICES

Pharmacy:	Phone:
Address:	Fax:
City/State/Zip:	Email:

Neurology Referral Form

Please attach copy of insurance cards (front and back)

Last Name:	First Name:		DOB:	Practice:	
Address:				Address:	
City:	State:	Zip:	Sex: ○M ○F	City: State:	Zip:
Phone:	SSN#			Prescriber Name:	
Insurance Information				Prescriber NPI:	
Insurance Plan:	Insurance Plan:			Nurse/Key Contact:	
Policy #	Policy #			Phone:	
Plan #	Plan #			Fax:	Email:

Diagnosis and Clinical Information

Please attach clinical/progress notes, labs, test supporting primary diagnosis

Diagnosis	ICD-10 Code
1.	
2.	
3.	
4.	
5.	
6.	

Allergies:

NKDA:

Height:

Weight:

Prescription Information

Medication	Directions	QTY	Refills
☐ IVIg	Administer ____ gm/kg per day for ____ days every ____ weeks		
☐ SCIg	Administer ____ gm/kg per day for ____ days every ____ weeks		
☐ Aduhelm *(aducanumab-avwa)*	IV every 4 weeks as follows: 1 mg/kg for infusions 1 and 2; 3 mg/kg for infusions 3 and 4 6mg/kg for infusions 5 and 6; 10mg/kg for Infusions 7 and beyond		
☐ Briumvi *(ublituximab)*	First infusion: 150mg IV infusion Second infusion: 450mg IV infusion at 2 weeks after first infusion Followed by 450mg IV every 24 weeks		
☐ Kisunla *(donanemab-azbt)*	700 mg administered over approximately 30 minutes every 4 weeks for the first three doses Followed by 1,400mg every 4 weeks thereafter		
☐ Lemtrada *(alemtuzumab)*	First infusion: 12mg IV infusion for 5 consecutive days Second infusion: 12mg IV infusion for 3 consecutive days 12 months after first infusion		
☐ Leqembi *(lecanemab-irmb)*	10mg/kg IV every 2 weeks **MRIs at baseline, prior to 5th, 7th and 14th infusions*		
☐ Ocrevus *(ocrelizumab)*	Starting dose: Infuse 300mg IV on day 1 and day 15 Maintenance dose: Infuse 600mg IV once every 6 months		
☐ Radicava *(edaravone)*	Starting dose: 60mg IV daily for 14 days followed by a 14-day drug-free period Maintenance dose: 60mg IV daily for 10 days out of 14 followed by a 14-day drug-free period		
☐ Rystiggo *(rozanolixizumab)*	☐ <50kg = 420mg ☐ 50kg to <100kg = 560mg ☐ >100 = 840mg **Cycle may be repeated > 63 days* Dose above once weekly x 6 weeks.		
☐ Soliris *(eculizumab)*	Starting dose: 900mg IV weekly for 4 weeks, followed by 1,200mg IV for the fifth dose 1 week later Maintenance dose: 1,200mg IV every 2 weeks		
☐ Tysabri *(natalizumab)*	Infuse 300mg IV every 4 weeks		
☐ Ultomiris *(ravulizumab)*	☐ 40-59kg Starting dose: 2,400mg IV followed in 2 weeks by maintenance dose of 3,000mg IV every 8 weeks ☐ 60-99kg Starting dose: 2,700mg IV followed in 2 weeks by maintenance dose of 3,300mg IV every 8 weeks ☐ ≥ 100kg Starting dose: 3,000mg IV followed in 2 weeks by maintenance dose of 3,600mg IV every 8 weeks		
☐ Uplizna *(inebilizumab-cdon)*	Starting dose: 300mg IV followed by 300mg at 2 weeks Maintenance dose: 300mg IV starting 6 months after first infusion		
☐ Vyepti *(eptinezumab-jjmr)*	☐ 100mg IV every 12 weeks ☐ 300mg IV every 12 weeks		
☐ Vyvgart *(efgartigimod alfa)*	10mg/kg (1,200mg for weight >120kg) IV once weekly for _____ weeks with _____ weeks between cycles		
☐ Vyvgart-Hytrulo *(efgartigimod alfa and hyaluronidase-QVFC)*	☐ Myasthenia gravis: 1,008mg efgartigimod alfa/11,200 units hyaluronidase once weekly for 4 weeks ☐ CIDP: 1,008mg efgartigimod alfa/11,200 units hyaluronidase once weekly (indefinitely)		
☐ Other			

Neurology Referral Form- Continued	
Pre-medication	
☐ NS Hydration	_____ mLs NS IV to be infused prior/post infusion
☐ Acetaminophen	1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	_____ Take 1 tablet PO prior to infusion or as directed _____ 50mg IV prior to infusion or as directed
☐ Anaphylaxis	Anaphylaxis per pharmacy protocol
☐ Other	

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above that I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN. STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED.