Neurology Infusion

Referral Form

PLEASE ATTACH INSURANCE CARDS - FRONT AND BACK

Email: intake@infuseoneohio.com
Fax: (614) 929-7199
☐ Dublin, OH ☐ Lancaster, OH

INFUSE ONE OHIO

PATIENT INFORMATION

Last Name, First Name _____ **Date of Birth** _____ **Gender** ☐ M ☐ F

Address _____ **City, State, ZIP** _____ **Phone** _____

REFERRING PROVIDER INFORMATION

Referring Practice _____ **Practice Address / City / State / ZIP** _____

Prescriber Name _____ **Prescriber NPI** _____ **Nurse / Key Contact** _____ **Phone** _____

Fax _____ **Email** _____

INSURANCE INFORMATION

PRIMARY **Insurance Plan** _____ **Policy #** _____ **Plan ID** _____

Secondary Insurance Plan _____ **Secondary Policy #** _____ **Secondary Plan ID** _____

DIAGNOSIS & CLINICAL INFORMATION

Attach clinical/progress notes, labs, tests, and supporting diagnosis

DIAGNOSIS	ICD-10
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		
☐ Ocrevus (ocrelizumab)	Starting: 300mg IV day 1 and day 15. Maintenance: 600mg IV every 6 months.		
☐ Tysabri (natalizumab)	300mg IV every 4 weeks.		
☐ Briumvi (ublituximab)	150mg IV first; 450mg IV 2 weeks later; then 450mg IV every 24 weeks x 1 year.		
☐ Lemtrada (alemtuzumab)	12mg IV x5 consecutive days; second course 12mg IV x3 days, 12 months later.		
☐ Vyvgart (efgartigimod alfa)	10mg/kg IV weekly x4 (<120kg); 1200mg/kg IV weekly x4 (<120kg); 200mg if >120kg. Repeat cycle >50 days.		
☐ Vyvgart Hytrulo	1,008mg / 11,200 units SC weekly x4 (efgartigimod alfa and hyaluronidase-QVFC).		
☐ Rystiggo (rozanolixizumab)	<50kg=420mg; 50-<100kg=560mg; >100kg=840mg. Repeat cycle >63 days.		
☐ Ultomiris (ravulizumab)	Start 2,400/2,700/3,000mg by weight; in 2 weeks maintain 3,000/3,300/3,600mg IV every 8 weeks.		
☐ Soliris (eculizumab)	900mg IV weekly x4; 1200mg IV 1 week later; then 1200mg IV every 2 weeks.		
☐ Uplizna (inebilizumab-cdon)	300mg IV, repeat 300mg at 2 weeks; maintenance 300mg IV 6 months after first infusion.		
☐ Radicava (edaravone)	60mg IV daily x14, then 14 drug-free days; maintain 60mg IV 10 of 14 days, then 14 drug-free days.		
☐ Vyepti (eptinezumab-jjmr)	100mg IV every 12 weeks OR 300mg IV every 12 weeks.		
☐ Leqembi (lecanemab-irmb)	10mg/kg IV every 2 weeks. MRIs baseline and prior to 5th, 7th, and 14th infusions.		
☐ Kisunla (donanemab-azbt)	700mg IV every 4 weeks x3, then 1400mg IV every 4 weeks. MRIs baseline and prior to 2nd, 3rd, 4th, 7th.		
☐ Other			

PRE-MEDICATION

☐ NS Hydration	_____ mL NS IV prior/post infusion
☐ Acetaminophen	1-2 tablets PO prior to or post-infusion as directed
☐ Diphenhydramine	_____ 1 tablet PO prior/as directed _____ 50mg IV prior/as directed
☐ Anaphylaxis	Per pharmacy protocol
☐ Other	_____

AUTHORIZATION, SIGNATURE & REQUIRED ATTACHMENTS

I authorize Infuse One Ohio to initiate required insurance prior authorization for this prescription and future refills. I may revoke this designation at any time by written notice.

Physician Signature _____ **Date** _____

☐ Patient demographics
☐ Medical insurance card - front/back
☐ Pharmacy card - front/back, if available
☐ Most recent chart notes, diagnostic testing, and labs
☐ Proof of concurrent treatment with other biologics