

NEUROLOGY ENROLLMENT FORM

Ph: 949.667.4325 | Fax: 714.485.7063 | altheainfusion.com | altheapharmacy.com



Patient Name: _____ DOB: / / Height: _____ Weight: _____ kg Date: / /
 Allergies: _____ Email: _____ Ship to: Patient
 Address: _____ Ph: _____ Prescriber Signature MD Office
 Prescriber: _____ Ph: _____ Fax: _____ Althea Location: _____

DOCUMENTS TO INCLUDE WITH REFERRAL | DIAGNOSIS

- Patient demographics
- Face sheet
- Insurance information
- Recent Lab Results** (Required): Antibody panel, BUN/SCr, IgA level, and EMG/NCV studies
- H&P
- Medications and therapies tried and failed
- Baseline assessment, including detailed patient symptoms
- Attach original prescription orders

- G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) M33.10
- Dermatomyositis
- G61.0 Guillian-Barré Syndrome
- G70.80 Lambert-Eaton Syndrome
- G61.82 Multifocal Motor Neuropathy (MMN)
- G35 – Multiple Sclerosis (RRMS subtype)
- G70.01 Myasthenia Gravis w/Acute Exacerbation
- G13.0 Paraneoplastic Syndrome
- M33.22 Polymyositis
- G25.82 Stiff-Person Syndrome
- L10.0 Pemphigus Vulgaris
- D69.3 Immune Thrombocytopenic Purpura (ITP)
- Other: _____

IMMUNE GLOBULIN PRESCRIPTION (IVIG) | SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

Loading Dose: _____ grams/kg infused over _____ day(s)
 _____ grams daily for _____ day(s)
Maintenance: _____ grams/kg infused over _____ day(s)
 _____ grams daily for _____ day(s)
 Repeat course every _____ week(s) refill x 1 year

SCIG _____ grams monthly **OR** _____ grams every _____ weeks.
 Refill x 1 year. Pharmacy to select number of infusion sites and needle length.

OK to round to the nearest vial size. +/- 4 days to allow scheduling flexibility.

Multiple doses will be administered on consecutive days unless ordered otherwise. **Non-consecutive days OK**

NEUROLOGY PRESCRIPTION | DOSAGE AND ADMINISTRATION

Tepezza® (teprotumumab-trbw)	10 mg/kg intravenously on day 1, followed by 20 mg/kg intravenously every 3 weeks for 7 additional infusions (total of 8 infusions).
Ocrevus® (ocrelizumab)	LOADING DOSE: Infuse Ocrevus 300mg / 250ml NS intravenously on weeks 0 and 2 (+/- 4 days). Infuse over 2.5 hours. MAINTENANCE DOSE: Infuse Ocrevus 600mg / 500ml NS intravenously over approximately 2 hours, every 6 months (+/- 7 days), starting 6 months after week 0.
Soliris® (eculizumab)	900 mg intravenously weekly for the first 4 weeks, followed by 1200 mg intravenously at week 5, then 1200 mg intravenously every 2 weeks thereafter.
Rituxan® (rituximab) Ruxience® (rituximab-pvvr) Truxima® (rituximab-abbs)	1000mg intravenously on day 1 and 15 for 2 doses, then 1000mg intravenously once every 6 to 12 months.
Tysabri® (eculizumab)	Infuse 300mg/mcg intravenously every four weeks.
Uplizna® (inebilizumab-cdon)	300 mg intravenously on day 1 and day 15, followed by 300 mg intravenously every 6 months thereafter.
Leqembi® (lecanemab-irmb)	Initiation Period: 10mg/kg intravenously once every 2 weeks for first 18 months. Maintenance Period: 10mg/kg intravenously once every 4 weeks after 18 months.
Ultomiris® (ravulizumab-cwvz)	Administer a loading dose followed 2 weeks later by weight-based maintenance dosing every 8 weeks.
Other: _____	_____

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.

Premedications & Other Medications - Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

Acetaminophen _____ mg PO prior to infusion Diphenhydramine _____ mg PO Other: _____