

NEUROLOGY ENROLLMENT FORM

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* 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
- * Patient demographics
 - * Copies of insurance card (front and back)
 - * Pharmacy Card
 - * **Recent Lab Results:** Antibody panel, BUN/SCr, IgA level, and EMG/NCV studies
 - * Specialist consults and recent progress notes
 - Prior medications and therapies (failed or inadequate response)
 - Relevant imaging studies (MRI, CT, X-ray, etc.)
 - Baseline functional assessment with detailed symptom history

- ### DIAGNOSIS
- 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)

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

SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

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

Brand Name: _____ Multiple doses will be administered on consecutive days unless ordered otherwise. **Non-consecutive days OK** OK to round to the nearest vial size. +/- 4 days to allow scheduling flexibility.

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.
Briumvi® (ublituximab-xiyy)	150 mg intravenously on Day 1 over 4 hours; 450 mg intravenously on Day 15 over 1 hour; then 450 mg intravenously every 24 weeks over 1 hour.
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
 Methylprednisolone Other: _____