ameripharma™ SPECIALTY CARE

NEUROLOGY ORDER SET

P: (877) 778-0318 F: (877) 778-0399

Patient Information

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ❑ New to Therapy ❑ Continuing Therapy **Next Treatment Date:** _____

Patient Weight: _____ lbs. (required) Allergies: _____

Lab Orders: _____ Frequency: ❑ Each infusion ❑ Other: _____

Diagnosis	Infusion Orders
❑ Pompe Disease **ICD-10 Code:** _____	❑ **Lumizyme** 20mg/kg IV every 2 weeks x1 year ❑ **Nexviazyme** 20mg/kg IV every 2 weeks x1 year
❑ MS ❑ Other: _____ **ICD-10 Code:** _____	❑ **Solu-Medrol** 1gm IV daily x _____ days ❑ **Solu-Cortef** 1gm IV daily x _____ days
❑ Diagnosis: _____ **ICD-10 Code:** _____	**Soliris:** ❑ 900mg IV weekly for the first 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg every 2 weeks thereafter x1year (initial start with maintenance) *(neuro dosing)* ❑ 1200mg IV every 2 weeks x1 year (maintenance dosing)
❑ Multiple Sclerosis **ICD-10 Code:** _____	❑ **Tysabri** 300mg IV every 4 weeks (after registering patient with TOUCH) ❑ **Ocrevus*** ❑ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year ❑ 600mg IV every 6 months x1 year ❑ **Briumvi*** ❑ 150mg IV x1, then 450mg IV 2 weeks later, followed by 450mg IV every 24 weeks x1 year ❑ 450mg IV every 24 weeks x1 year ***Premed Protocol:** Solu-Medrol 100mg IV and Benadryl 25mg PO/IV to be given 30 minutes before infusion
❑ Diagnosis: _____ **ICD-10 Code:** _____	**IVIg** Orders: _____ mg/kg OR _____ gm/kg IV divided over _____ day(s) **Frequency:** Every _____ weeks x1 year OR _____ one time dose only **Preferred Brand:** _____ (AmeriPharma to choose if not indicated)
❑ Diagnosis: Myasthenia Gravis **ICD-10 Code:** _____	**Ultomiris** *(neuro dosing)*: Loading dose: ❑ 2,400mg (40-59kg) ❑ 2,700mg (60-99kg) ❑ 3,000mg (100+kg) IV followed 2 weeks later by maintenance dose of: ❑ 3,000mg (40-59kg) ❑ 3,300mg (60-99kg) ❑ 3,600mg IV (100kg+) IV every 8 weeks x1 year **Vyvgart*:** ❑ 10mg/kg IV once weekly for 4 weeks (<120kg) ❑ 1200mg IV over 1 hour once weekly for 4 weeks (≥120 kg) **Cycle may be repeated >50 days from start of previous cycle. Subsequent cycles may be ordered as appropriate*
❑ hATTR amyloidosis **ICD-10 Code:** _____	❑ **Amvuttra** 25mg SubQ every 3 months x1 year
Pre-medication Orders	❑ Tylenol 1000mg PO ❑ Cetirizine 10mg PO ❑ Benadryl 25mg PO ❑ Benadryl 25mg IV ❑ Loratadine 10 mg PO ❑ Solu-Medrol _____ mg IVP ❑ Other: _____
Flushing Protocol	☒ Sodium Chloride 0.9% 5-10 mL per SASH protocol ❑ Heparin 3-5 mL per SASH protocol Determined by IV access: PIV (50 u/mL) OR Port/PICC (500 u/mL)

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30 kg (>66lbs): EpiPen® 0.3mg use as directed for anaphylaxis; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen® 0.15mg use as directed for anaphylaxis; may repeat in 5-10 minutes x1
- Diphenhydramine - Administer 25-50mg orally OR IV (adult), refer to provider orders or policy for pediatric dose
- NS 500 mL IV bolus as needed for IVIg therapy (adult), refer to provider orders or policy for pediatric bolus

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Provider Information

Provider Name: _____ Provider's Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

❑ Opt out of AmeriPharma selecting site of care (if checked, please list site of care): _____ _____ _____

City State

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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COMPREHENSIVE SUPPORT FOR NEUROLOGY THERAPY

Patient Information

Patient Name: _____ DOB: _____

Required Documentation for Referral Processing & Insurance Approval

- ❑ Include signed and completed order (MD/prescriber to complete page 1)
- ❑ Include patient demographic information and insurance information
- ❑ Include patient's medication list
- ❑ Supporting clinical notes (H&P) to support diagnosis

  Has the patient tried and failed previous drug therapy? ❑ Yes ❑ No

  If yes, which drug(s)? _____

- ❑ Labs attached
  - ❑ JCV antibody (Tysabri orders)
  - ❑ AChR antibody (Vyvgart & Ultomiris)
  - ❑ Hepatitis B antigen and Hepatitis B core total (Ocrevus & Briumvi orders)
  - ❑ Serum immunoglobulins (Ocrevus & Briumvi)
  - ❑ Other supporting labs based on diagnosis/order
- ❑ Diagnostic testing
  - ❑ MRI documentation (Tysabri, Ocrevus, Briumvi)
  - ❑ Other diagnostic testing to support diagnosis/order
- ❑ Vaccine record
  - ❑ Meningococcal vaccinations - both Men B and Men ACWY (Soliris & Ultomiris orders)
- ❑ Other medical necessity: _____

AmeriPharma Specialty Care will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer them to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (877) 778-0399 or call (877) 778-0318 for assistance.

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