ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

NEUROLOGY ORDER FORM

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐ Male ☐ Female	Weight:	☐ lbs ☐ kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

MEDICAL INFORMATION

(Check any that apply)

Allergies: | Date of last infusion:

☐ Clinical / Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ Last MRI documentation attached

☐ Patient's TOUCH authorization (only for Tysabri orders)

☐ Hepatitis B antigen and Hepatitis B Core total antibody required

☐ Quantitative Serum Immunoglobulin Screening (only for Ocrevus orders)

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders:

INFUSION ORDERS

☐ Migraines
ICD-10 _____

Pre-Medication

☐ Zofran 4mg slow IVP ☐ Zofran 8mg IVP ☐ Pepcid IV 20mg IVP ☐ Toradol 30mg IVP

☐ Solu-Medrol ___ mg IVP ☐ Reglan 10mg IV/100ml NS over 20 minutes

Protocol:

☐ Depacon ☐ 500mg ☐ 750mg in 250mL NS ☐ Magnesium Sulfate 1gm IV in 250mL

☐ DHE 45 ☐ 0.5mg ☐ 1mg IV in 100mL NS (must be premed for nausea)

☐ **File this as a standing order for _____ months**

☐ Multiple Sclerosis Exacerbation
ICD-10 _____

☐ **Solu-Medrol**_____ gm IV daily x _____days ☐ **Solu-Cortef** _____gm IV daily x _____days

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☐ Multiple Sclerosis
ICD-10 _____

☐ Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH)

☐ JCV Test Result_____

Pre-medication protocol: Acetaminophen _____mg PO and Diphenhydramine_____PO

Date of last interferon dose _____

☐ Ocrevus ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months

☐ 600mg IV every 6 months ☐ 2 Hour Rapid Infusion

Pre-medication protocol: Solu-Medrol _____ IV and Diphenhydramine _____mg IV, and Acetaminophen _____mg PO to be given 30 minutes before infusion.

Date of last interferon dose _____

Hypersensitivity/Anaphylaxis Response Protocol PRN

IVIG ORDERS

Diagnosis: _____ **ICD-10:** _____ **IVIG Brand** _____

IVIG Orders:_____**mg/kg or** _____**gm/kg IV divided over** _____ **day (s)**

Protocol Pre-Medication Orders: Tylenol 1000mg PO

Frequency: Every_____**weeks or** _____ **one time dose**

please choose one antihistamine: ☐ Cetrizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol_____mg IVP

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____ ☐ DAW(Dispense as Written) Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.