NEUROLOGY
ORDER FORM

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

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

MEDICAL INFORMATION

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

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

Labs 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

☐ 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 _____

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INFUSION ORDERS

☐ Multiple Sclerosis
ICD-10 _____

☐ 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

Ocrevus Zunovo (ocrelizumab/hyaluronidase)

☐ Dexamethasone 20mg PO (or equivalent corticosteroid)
☐ Diphenhydramine 25mg
☐ Diphenhydramine 50mg PO (or equivalent antihistamine)
30minutes prior to infusion
Observe patient for 1 hour initial dose and 15 mins subsequent dose

Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

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

Date

☐ DAW (Dispense as written).

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.

Prescriber's Signature

X _____

Please fax all information to (832)939-8128 or call (877)993-3548 for assistance