NEUROLOGY ENROLLMENT FORM

Ph: xxx.xxx.xxx | Fax: xxx.xxx.xxx | altheainfusion.com

ALTHEA INFUSION

Patient Name: _____ DOB: / / Height: _____ Weight: _____kg Date: / /

Allergies: _____ Email: _____

Address: _____ Ph: _____

Prescriber: _____ Ph: _____ Fax: _____

Ship to:

- ☐ Patient
- ☐ MD Office
- ☐ Althea Location: _____

DOCUMENTS TO INCLUDE WITH REFERRAL

- 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

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 1year

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

SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

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

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

NEUROLOGY PRESCRIPTION	DOSAGE AND ADMINISTRATION
☐ Briumvi® (ublituximab-xiiy)	150mg intravenously once on day 1, followed by 450mg intravenously once 2 weeks later, subsequent doses of 450mg are administered once every 24 weeks (beginning 24 weeks after the first dose of 150mg).
☐ 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.
☐ Ocrevus Zunovo® (ocrelizumab and hyaluronidase-ocsq)	Ocrelizumab 920mg/Hyaluronidase 23,000 units subcutaneously every 6 months.
☐ 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.
☐ Vyepti® (eptinezumab-jjmr)	100mg/300mg intravenously every 3 months.
☐ Vyvgart® (efgartigimod alfa-fcab)	10mg/kg intravenously once weekly for 4 weeks.
☐ Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)	Hytrulo 1,008 mg efgartigimod alfa/11,200 units hyaluronidase once weekly x _____ weeks

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: _____