NEUROLOGY ENROLLMENT FORM

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ALTHEA
INFUSION & SPECIALTY PHARMACY™

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

Allergies: _____ Email: _____

Address: _____ Ph: _____

★ Prescriber: _____ Ph: _____ Fax: _____

Ship to: ☐ Patient ☐ MD Office ☐ Althea Location:

★ Prescriber Signature _____

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 1year

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.

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-xiiy)	☐ 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: ☐ _____