NEUROLOGY ENROLLMENT FORM

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ALTHEA INFUSION & SPECIALTY PHARMACY

Patient Name: _____ **DOB:** _____ **Height:** _____ **Weight (kg):** _____ **Date:** _____

Allergies: _____ **Email:** _____ **Phone:** _____

Address: _____ **Ship to:** ☐ Patient ☐ MD Office ☐ Althea Location

DIAGNOSIS (ICD-10) — check all that apply

- ☐ G61.81 – Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ M33.10 – Dermatomyositis
- ☐ G61.0 – Guillain-Barre Syndrome
- ☐ G70.80 – Lambert-Eaton Syndrome
- ☐ G61.82 / G25.82 – Multifocal Motor Neuropathy / Stiff-Person
- ☐ G35 – Multiple Sclerosis (RRMS subtype)
- ☐ G70.00 – Myasthenia Gravis
- ☐ G13.0 – Paraneoplastic Syndrome
- ☐ M33.20 – Polymyositis
- ☐ D69.3 – Immune Thrombocytopenic Purpura (ITP)
- ☐ L10.0 – Pemphigus Vulgaris
- ☐ G36.0 – Neuromyelitis Optica Spectrum Disorder (NMOSD)
- ☐ E05.00 – Graves' Disease / Thyroid Eye Disease (TED)
- ☐ G30.9 / G31.84 – Alzheimer's Disease / Mild Cognitive Impairment
- ☐ Other: _____

IMMUNE GLOBULIN PRESCRIPTION (IVIG / SCIG)

IVIG Brand: ☐ Octagam 5% ☐ Octagam 10% ☐ Panzyga 10% ☐ Privigen 10% ☐ Gammagard 5% ☐ Gammagard 10% ☐ Gamunex-C 10%

Route: ☐ IVIG ☐ SCIG **Preferred Brand:** ☐ Pharmacist to determine ☐ Specify: _____

Product: _____ **Dose:** _____ g/kg **Frequency:** _____ **Qty:** _____ ***Refills:** _____

Substitution Permitted: ☐ Yes ☐ No **Infuse Over:** _____ days **Max Rate:** _____ cc/hr

NEUROLOGY PRESCRIPTION — DOSAGE AND ADMINISTRATION

☐ **Tepezza ®** (teprotumumab-trbw)	10 mg/kg IV on day 1, then 20 mg/kg IV every 3 weeks for 7 additional infusions (total of 8 infusions).
☐ **Ocrevus ®** (ocrelizumab)	Loading: 300 mg/250 mL NS IV on weeks 0 and 2 (+/-4 days), over 2.5 hrs. Maintenance: 600 mg/500 mL NS IV over ~2 hrs, every 6 months (+/-7 days), starting 6 months after week 0.
☐ **Briumvi ®** (ublituximab-xiiy)	150 mg IV on Day 1 over 4 hrs; 450 mg IV on Day 15 over 1 hr; then 450 mg IV every 24 weeks over 1 hr.
☐ **Uplizna ®** (inebilizumab-cdon)	300 mg IV on day 1 and day 15, then 300 mg IV every 6 months thereafter.
☐ **Soliris ®** (eculizumab)	900 mg IV weekly x4 weeks, then 1200 mg IV at week 5, then 1200 mg IV every 2 weeks thereafter.
☐ **Ultomiris ®** (ravulizumab-cwvz)	Administer a loading dose followed 2 weeks later by weight-based maintenance dosing every 8 weeks.
☐ **Rituxan ®** (rituximab) / **Ruxience ®** (rituximab-pvvr) / **Truxima ®** (rituximab-abbs)	1000 mg IV on day 1 and 15 for 2 doses, then 500 mg IV maintenance at month 12 and every 6 months thereafter.
☐ **Leqembi ®** (lecanemab-irmb)	Initiation: 10 mg/kg IV every 2 weeks for first 18 months. Maintenance: 10 mg/kg IV every 4 weeks after 18 months.
☐ **Kisunla ®** (donanemab-azbt)	350 mg IV infusion 1, 700 mg infusion 2, 1050 mg infusion 3, then 1400 mg IV every 4 weeks thereafter.

☐ **Other:** _____

PREMEDICATION ORDERS / OTHER MEDICATIONS

Flush Protocol — per S.A.S.H. (Saline, Administer med, Saline, Heparin), volumes/concentrations per line type. Anaphylaxis Kit orders as per protocol below.

Refills entered in the Prescription section above also apply to premedications.

☐ Acetaminophen _____ mg PO ☐ Diphenhydramine _____ mg PO/IV ☐ Methylprednisolone _____ mg PO/IV

☐ Other: _____

ANAPHYLAXIS KIT & HYDRATION STANDING ORDERS

Authorizes RNs/LVNs to administer the following without a separate patient-specific order, per protocol, for 1 year from signature date.

Anaphylaxis Kit — check to authorize:

- ☐ Epinephrine 1:1000, 0.3 mg IM; may repeat q5-15 min PRN
- ☐ Sodium Chloride 0.9%, 500 mL IV bolus x1
- ☐ Methylprednisolone 125 mg IV push x1
- ☐ Diphenhydramine 50 mg IV or IM x1

Hydration Kit — base fluid always given; check to remove:

Base: Sodium Chloride 0.9%, 500 mL IV over 30 min

- ☐ Remove Vitamin B-12 1,000 mcg
- ☐ Remove Calcium Gluconate 180 mg
- ☐ Remove Magnesium Chloride 800 mg
- ☐ **DO NOT INFUSE hydration kit for this patient**

Infusion Reaction Protocol — check to authorize:

Vitals per protocol: prior to infusion, q15 min during rate escalation, hourly thereafter, and at completion. Watch for dyspnea or rash.

For any reaction: stop infusion and administer meds as applicable, then notify prescriber.

- ☐ Acetaminophen 325 mg PO for headache, temp > 101°F
- ☐ Diphenhydramine 25 mg PO or Loratadine 10 mg PO for itching/rash
- ☐ Methylprednisolone IV for persistent or severe reaction

If symptom resolves, resume treatment at 50% rate after 30 min, then titrate to patient tolerance. If severe/symptomatic, do not restart.

CLINICAL PARAMETERS & HOLD CRITERIA

Hydration Kit — do NOT infuse if:

Vitals: SBP > 160, DBP > 100, or HR > 100 bpm
Labs: Ca > 10.5, Mg > 2.6, eGFR < 90, or BNP > 100
Pregnancy/breastfeeding; signs of CHF, ESRD, liver cirrhosis, or shortness of breath/edema

Anaphylaxis — initiate immediately if rapid onset of:

Respiratory: wheezing, stridor, throat tightening, or SpO2 < 92%
Circulatory: SBP < 90 (or drop > 20 w/ symptoms), HR > 110, or syncope
Skin/GI: angioedema, generalized hives, severe cramps

Emergency sequence: Stop infusion (keep IV access) → Call 911 → Give epinephrine IM → Do not restart infusion → Monitor vitals q1–2 min, transport via EMS, and notify prescriber and pharmacy in SBAR format once stable.

PRESCRIBER AUTHORIZATION

By signing below, I authorize Althea Infusion & Specialty Pharmacy to dispense the immune globulin and/or neurology prescription(s) indicated above, and I authorize California-licensed RNs/LVNs to administer the Anaphylaxis Kit and Hydration Kit standing orders as indicated above. I assume clinical responsibility for these orders, which remain in effect for 1 year from the date below or until rescinded by me in writing.

Prescriber Name: _____ **NPI:** _____ **DEA:** _____ **CA Lic:** _____

Phone: _____ **Fax:** _____ **Specialty:** _____

Prescriber Signature: _____ **Date:** _____