DeliverIt Pharmacy Infusion & Specialty

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NEUROLOGY ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________ Social Sec #: __________ Weight: ____ lbs

D.O.B: __________ Sex: Male ____ Female _____ Height: ____ lbs

Phone: ______________

Address: ______________________________ City: ________ State: ____ Zip Code: ________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

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 *(only for Ocrevus orders)*

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physcian

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
☐ 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

PHYSICIAN INFORMATION

By signing this form and utilizing your services, you are authorizing DeliverIt Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ______________________________ Date: ________________

Physician Name: ______________________________

Phone: ______________ Fax: ______________ Contact Person: ________________