

**NEUROLOGY REFERRAL FORM**

**Century Specialty Script**  
**Fax Referral To: 877-521-5353**  
**Phone: 800-521-3949**



Date: \_\_\_\_\_

Current Patient     New Patient

**Patient Information**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender:  M  F

**Prescriber Information**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 DEA: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_  
 Prescription Card: \_\_\_\_\_ ID#: \_\_\_\_\_ BIN#: \_\_\_\_\_ PCN#: \_\_\_\_\_ Group: \_\_\_\_\_

**Diagnosis & Lab Work (Fill in below or attach lab work)**

Primary Diagnosis: \_\_\_\_\_ Allergies: \_\_\_\_\_ Previously failed meds: \_\_\_\_\_  
 Expected Date of First/Next Administration: \_\_\_\_\_ Date of Last Administration (if applicable): \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Is the patient up to date on all required labs/vaccinations as required by therapy?  Yes  No

**Please Attach Laboratory Results and Clinical Information.**

**Prescription Information**

Medication	Dose Strength	Directions	Qty	Refills
<input type="checkbox"/> Copaxone <input type="checkbox"/> Glatiramer Acetate <input type="checkbox"/> Glatopa	<input type="checkbox"/> 20mg/mL PFS <input type="checkbox"/> 40mg/mL PFS	<input type="checkbox"/> Inject 20mg SUBQ daily <input type="checkbox"/> Inject 40mg SUBQ three times per week		
Imaavy	<input type="checkbox"/> 300 mg/1.62mL vial <input type="checkbox"/> 1200mg/6.5ml vial	<input type="checkbox"/> <b>Loading Dose:</b> 30mg/kg IV x 1 over ≥ 30 minutes <input type="checkbox"/> <b>Maintenance Dose:</b> (Start 2 weeks after loading dose) 15mg/kg IV q 2 weeks over ≥ 15 minutes		
Kesimpta	<input type="checkbox"/> 20mg/0.4ml Pen	<input type="checkbox"/> <b>Loading Dose:</b> 20mg SUBQ weeks 0, 1, 2. <input type="checkbox"/> <b>Maintenance Dose:</b> 20 mg SUBQ once a month (starting week 4)		
Rystiggo	<input type="checkbox"/> 280mg/2mL vial <input type="checkbox"/> 420mg/3mL vial <input type="checkbox"/> 560mg/4mL vial <input type="checkbox"/> 840mg/6mL vial	<input type="checkbox"/> <b>Loading Dose for weight &lt; 50kg:</b> 420mg SUBQ once weekly x 6 weeks <input type="checkbox"/> <b>Loading Dose for weight ≥ 50 to &lt; 100kg:</b> 560 mg SUBQ once weekly x 6 weeks <input type="checkbox"/> <b>Loading Dose for weight ≥ 100kg:</b> 840 mg SUBQ once weekly x 6 weeks <input type="checkbox"/> <b>Maintenance Dose for weight &lt; 50kg:</b> 420mg SUBQ once weekly x 6 weeks. May repeat 63 days from start of prior treatment cycle. <input type="checkbox"/> <b>Maintenance Dose for weight ≥ 50 to &lt; 100kg:</b> 560mg SUBQ once weekly x 6 weeks. May repeat 63 days from start of prior treatment cycle. <input type="checkbox"/> <b>Maintenance Dose for weight ≥ 100kg:</b> 840 mg SUBQ once weekly x 6 weeks. May repeat 63 days from start of prior treatment cycle.		

**Flush Protocol**

**Premedication** to be given 30 minutes prior to infusion:  
 Acetaminophen PO: 325mg 500 mg 650mg  
 Diphenhydramine: 25 mg IVP 50mg IVP 25mg PO 50mg PO  
**OR** Alternate oral antihistamine: Cetirizine 10mg  Loratadine 10mg  
Fexofenadine 60mgs Fexofenadine 180mgs  
**IV Access Flush Order:** NaCl 0.9% 5-10ml IV before and after infusion  
 Methylprednisolone 125mg IVP 40mg IVP OR \_\_\_mg PO  
Others/Miscellaneous: \_\_\_\_\_

Diphenhydramine Administer 25 mg slow IV/IM may repeat x 1  
**Dispense:** 1 x 50 mg vial  
 Epinephrine Autoinjector  Administer 0.15mg (1:2000) IM (< 30 Kg)  
 Administer 0.3mg (1:1000) IM (≥ 30 Kg)  
**Dispense:** 1 package (2 pens)  
 Sodium Chloride 0.9% Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis  
**Dispense:** QS

**Prescriber Signature:** \_\_\_\_\_ **DAW (Dispense as Written)** **Date:** \_\_\_\_\_

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<b>NEUROLOGY REFERRAL FORM</b>	<b>Superior Pharmacy Solutions</b> <b>Fax Referral To: 866-416-3656</b> <b>Phone: 866-416-3655</b>	
Date: _____ <input type="checkbox"/> Current Patient <input type="checkbox"/> New Patient		

Patient Information	Prescriber Information
Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ Alternate Phone: _____ DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA: _____ NPI #: _____ Contact Person: _____

Insurance Information		
Primary Insurance: _____	ID#: _____	Group: _____
Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____ PCN#: _____ Group: _____

Diagnosis & Lab Work (Fill in below or attach lab work)		
Primary Diagnosis: _____	Allergies: _____	Previously failed meds: _____
Expected Date of First/Next Administration: _____		Date of Last Administration (if applicable): _____
Height: _____	Weight: _____	
Is the patient up to date on all required labs/vaccinations as required by therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Please Attach Laboratory Results and Clinical Information.**

Prescription Information				
Medication	Dose Strength	Directions	Qty	Refills

Vyvgart	<input type="checkbox"/> 400mg/20mL vial	<input type="checkbox"/> 10mg/kg once weekly x 4 weeks. <input type="checkbox"/> For patients ≥ 120 kg infuse 1200mg/dose <input type="checkbox"/> <b>Subsequent cycle:</b> 10mg/kg (max 1200 mg) IV once weekly x 4 weeks based on clinical evaluation and no sooner than 50 days from start of previous cycle.		
Vyvgart Hytrulo	<input type="checkbox"/> 1000mg-10,000units/5mL PFS  <input type="checkbox"/> 1008mg-11,200 units/5.6ml vials	<b>For MG</b> <input type="checkbox"/> <b>PFS:</b> 1000mg-10,000 units SUBQ over 20-30 seconds weekly x 4 weeks. Subsequent cycles based on clinical evaluation and no sooner than 50 days from start of previous cycle <input type="checkbox"/> <b>Vials:</b> 1008 – 11,200 units SUBQ over 30-90 seconds weekly x 4 weeks. Subsequent cycles based on clinical evaluation and no sooner than 50 days from start of previous cycle. <b>For CIDP</b> <input type="checkbox"/> <b>PFS:</b> 1000mg – 10,000 units SUBQ over 20-30 seconds weekly <input type="checkbox"/> <b>Vials:</b> 1008-11,200 units weekly SUBQ over 30-90 seconds weekly		

Flush Protocol	
<b>Premedication</b> to be given 30 minutes prior to infusion: <input type="checkbox"/> Acetaminophen PO: <input type="checkbox"/> 325mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 650mg Diphenhydramine: <input type="checkbox"/> 25 mg IVP <input type="checkbox"/> 50mg IVP <input type="checkbox"/> 25mg PO <input type="checkbox"/> 50mg PO <b>OR</b> Alternate oral antihistamine: <input type="checkbox"/> Cetirizine 10mg <input type="checkbox"/> Loratadine 10mg <input type="checkbox"/> Fexofenadine 60mgs <input type="checkbox"/> Fexofenadine 180mgs <b>IV Access Flush Order:</b> NaCl 0.9% 5-10ml IV before and after infusion  <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> 125mg IVP <input type="checkbox"/> 40mg IVP OR <input type="checkbox"/> ___mg PO <input type="checkbox"/> Others/Miscellaeous: _____	Diphenhydramine Administer 25 mg slow IV/IM may repeat x 1 <b>Dispense:</b> 1 x 50 mg vial  Epinephrine Autoinjector <input type="checkbox"/> Administer 0.15mg (1:2000) IM (< 30 Kg) <input type="checkbox"/> Administer 0.3mg (1:1000) IM (≥ 30 Kg) <b>Dispense:</b> 1 package (2 pens)  Sodium Chloride 0.9% Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis <b>Dispense:</b> QS

Prescriber Signature: _____	DAW (Dispense as Written) Date: _____
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