NEUROLOGY REFERRAL FORM

Date: _____

☐ Current Patient ☐ New Patient

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

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
☐ Copaxone ☐ Glatiramer Acetate ☐ Glatopa	☐ 20mg/mL PFS ☐ 40mg/mL PFS	☐ Inject 20mg SUBQ daily ☐ Inject 40mg SUBQ three times per week		
Imaavy	☐ 300 mg/1.62mL vial ☐ 1200mg/6.5ml vial	☐ **Loading Dose**: 30mg/kg IV x 1 over ≥ 30 minutes ☐ **Maintenance Dose**: (Start 2 weeks after loading dose) 15mg/kg IV q 2 weeks over ≥ 15 minutes		
Kesimpta	☐ 20mg/0.4ml Pen	☐ **Loading Dose**: 20mg SUBQ weeks 0, 1, 2. ☐ **Maintenance Dose**: 20 mg SUBQ once a month (starting week 4)		
Rystiggo	☐ 280mg/2mL vial ☐ 420mg/3mL vial ☐ 560mg/4mL vial ☐ 840mg/6mL vial	☐ **Loading Dose for weight < 50kg**: 420mg SUBQ once weekly x 6 weeks ☐ **Loading Dose for weight ≥ 50 to < 100kg**: 560 mg SUBQ once weekly x 6 weeks ☐ **Loading Dose for weight ≥ 100kg**: 840 mg SUBQ once weekly x 6 weeks ☐ **Maintenance Dose for weight < 50kg**: 420mg SUBQ once weekly x 6 weeks. May repeat 63 days from start of prior treatment cycle. ☐ **Maintenance Dose for weight ≥ 50 to < 100kg**: 560mg SUBQ once weekly x 6 weeks. May repeat 63 days from start of prior treatment cycle. ☐ **Maintenance Dose for weight ≥ 100kg**: 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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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
Vyvgart	☐ 400mg/20mL vial	☐ 10mg/kg (max 1200 mg) IV once weekly for 4 weeks. (4 once-weekly infusions = 1 treatment cycle) with _____ weeks between infusion cycles. For patients ≥ 120 kg infuse 1200mg/dose		
Vyvgart Hytrulo	☐ 1008mg-11,200 units/5.6ml vials	**For MG** ☐ **Vials:** 1008 – 11,200 units SUBQ over 30-90 seconds once weekly for 4 weeks. (4 once-weekly injections= 1 treatment cycle) with _____ weeks between treatment cycles. **For CIDP** ☐ **Vials:** 1008-11,200 units weekly SUBQ over 30-90 seconds weekly		

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/Miscellaeous: _____

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:** _____