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Neurology Infusion Order

Patient name____DOB____________________

Phone number_____________________________________Weight_________________________

Diagnosis____ ICD 10 Code______________

Please do required test **HBsAg, anti-HBs, anti-HBc.** Add **Anti-JCV** for Tysabri.

_______ **Ocrevus**

_______Induction 300 mg IV on day 0 and day 15

_______ Maintenance 600 mg IV every 6 months

________ **Soloris**

_______ Induction 600 mg IV every week for 4 weeks, 900 mg IV given week 5

_______ Maintenance 900 mg IV every 2 weeks thereafter

_______ **Tysabri** 300 mg IV every 4 weeks

_______ **Vyepti** 100 mg______ or 300 mg_______ IV every 3 months

Pre Meds given PRN Yes or No (circle one)

____Diphenhydramine 25mg/50mg (circle one) IV/PO ____ Solu-Medrol 40mg IV ____Acetaminophen 650mg PO

_____ Other or additional instructions____

____

Is this a new treatment for this patient______________ or continuing treatment_________________

Prior tried and failed medications____

Contact person_____________________________ Phone_______________ Fax ________________

Name of ordering provider____

Ordering provider signature____ Date _______________

Order valid for 6 months.

Please fax this information, required tests, last two office notes, and insurance cards to infusion coordinator at 302-613-4697. Infusion coordinator can be reached at 302-483-7053.

Additional forms may be found on our website at ArthritisDE.com.