


NEUROLOGY REFERRAL FORM	SUPERIOR BIOLOGICS Fax Referral To: 914-747-1170 Phone: 855-747-1150	
Date: _____		
<input type="checkbox"/> Current Patient <input type="checkbox"/> New Patient		

Patient Information	Prescriber Information
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Alternate Phone: _____	DEA: _____ NPI #: _____
DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	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
<input type="checkbox"/> Copaxone	<input type="checkbox"/> 20mg/mL PFS	<input type="checkbox"/> Inject 20mg SUBQ daily		
<input type="checkbox"/> Glatiramer Acetate	<input type="checkbox"/> 40mg/mL PFS	<input type="checkbox"/> Inject 40mg SUBQ three times per week		
<input type="checkbox"/> Glatopa				
Imaavy	<input type="checkbox"/> 300 mg/1.62mL vial <input type="checkbox"/> 1200mg/6.5ml vial	<input type="checkbox"/> Loading Dose: 30mg/kg IV x 1 over ≥ 30 minutes <input type="checkbox"/> Maintenance Dose: (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"/> Loading Dose: 20mg SUBQ weeks 0, 1, 2. <input type="checkbox"/> Maintenance Dose: 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"/> Loading Dose for weight < 50kg: 420mg SUBQ once weekly x 6 weeks <input type="checkbox"/> Loading Dose for weight ≥ 50 to < 100kg: 560 mg SUBQ once weekly x 6 weeks <input type="checkbox"/> Loading Dose for weight ≥ 100kg: 840 mg SUBQ once weekly x 6 weeks <input type="checkbox"/> Maintenance Dose for weight < 50kg: 420mg SUBQ once weekly x 6 weeks. May repeat 63 days from start of prior treatment cycle. <input type="checkbox"/> Maintenance Dose for weight ≥ 50 to < 100kg: 560mg SUBQ once weekly x 6 weeks. May repeat 63 days from start of prior treatment cycle. <input type="checkbox"/> 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: <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 OR Alternate oral antihistamine: <input type="checkbox"/> Cetirizine 10mg <input type="checkbox"/> Loratadine 10mg <input type="checkbox"/> Fexofenadine 60mgs <input type="checkbox"/> Fexofenadine 180mgs IV Access Flush Order: 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/Miscellaneous: _____	Diphenhydramine Administer 25 mg slow IV/IM may repeat x 1 Dispense: 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) Dispense: 1 package (2 pens) Sodium Chloride 0.9% <i>Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis</i> Dispense: QS

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

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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"/> Subsequent cycle: 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	For MG <input type="checkbox"/> PFS: 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"/> Vials: 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. For CIDP <input type="checkbox"/> PFS: 1000mg – 10,000 units SUBQ over 20-30 seconds weekly <input type="checkbox"/> Vials: 1008-11,200 units weekly SUBQ over 30-90 seconds weekly		

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