


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

<b>Patient Information</b>	<b>Prescriber Information</b>
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"/> <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	
<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/Miscellaneous: _____	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% <i>Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis</i> <b>Dispense:</b> 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 (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	<input type="checkbox"/> 1008mg-11,200 units/5.6ml vials	<b>For MG</b> <input type="checkbox"/> <b>Vials:</b> 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.  <b>For CIDP</b> <input type="checkbox"/> <b>Vials:</b> 1008-11,200 units weekly SUBQ over 30-90 seconds weekly		

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